MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05229

5254

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 15 das.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center National Institutes of Health, Bethesda

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 103 North Van Buren Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Battaile — Last: Allnutt

4. DATE OF DEATH: Month: May — Day: 2, — Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 26 April 1887

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: 0 Days: 6
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: (Retired)

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry C.Allnutt

14. MOTHER'S MAIDEN NAME: Josephine Viers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Not available The Medical Record, Clinical Center, NIH

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Metastatic Melanoma to the Liver
DUE TO
(c):

190X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 17, 1956, to May 2, 1956, that I last saw the deceased alive on May 2, 1956, and that death occurred at 10, 25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. L. Fahey M.D.
ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda, Maryland
DATE SIGNED: 5/3/56
PHYSICIAN'S NAME (Type): John L. Fahey, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/5/1956
22c. NAME OF CEMETERY OR CREMATORY: Rockville Union
22d. LOCATION (City, town, or county) (State): Rockville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.

24a. REC'D BY REGISTRAR DATE: 6-7-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5232

CERTIFICATE OF DEATH

05230

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK

c. LENGTH OF STAY IN 1b: 1 MONTH

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7620 MAPLE AVENUE

d. STREET ADDRESS: 7620 MAPLE AVENUE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle GARNET Last GORDON BAILEY

4. DATE OF DEATH: Month MAY Day 27 Year 1956

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 4, 1890

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK, GOV'T. ACCOUNTING OFFICE, U.S. GOV'T.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): HAYS, KANSAS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALFRED D. BAILEY

14. MOTHER'S MAIDEN NAME: MARY GORDON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW #1

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. WALTER B. HARGETT, Address: 4325 Clagett Rd. University Park, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Heart Disease — 16 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 21, 1940, to May 27, 1956, that I last saw the deceased alive on May 10, 1956, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Marion Bankhead M.D. — ADDRESS (Street, city or town, state): 9241 Col. Hwy. Md. — DATE SIGNED: 5/27/56

PHYSICIAN'S NAME (Type): J. Marion Bankhead. Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/29/56

22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY

22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey — ADDRESS: SILVER SPRING, MARYLAND

24a. REC'D BY REGISTRAR DATE: 5/29/56

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Examiner (Dr. Bronfoot) notified & he O.K.'d my issuance of this certificate 5/27/56

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5255

06274

Reg. Dist. No. 2/6

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 1 Quincy Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NANNIE Middle Bell Last BAILEY

4. DATE OF DEATH: Month 5 Day 26 Year 1956

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 27 1897

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Major Marshall

14. MOTHER'S MAIDEN NAME: Laura

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Susie Bailey (Daughter) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Embolus	6 hours
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Myocardial Infarction	6 hours
DUE TO (c)	Arteriosclerotic Heart Disease	5 yrs

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 25, 1956, to May 25, 1956, that I last saw the deceased alive on May 25, 1956, and that death occurred at 4 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George Sharpe M.D. ADDRESS (Street, city or town, state): 10644 Connecticut Ave DATE SIGNED: 5-26-56

PHYSICIAN'S NAME (Type): George Sharpe Kensington, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/1/56

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat.

22d. LOCATION (City, town, or county) (State): Fort Myer Va.

23. FUNERAL DIRECTOR'S SIGNATURE: W. Ernest Jarvis Co. ADDRESS: 1432 You St. NW Wash. DC

24a. REC'D BY REGISTRAR DATE 6/1/56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5256

CERTIFICATE OF DEATH

05232

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 31 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

47X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

d. STREET ADDRESS: 1110 49th Place

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Susie — Middle: Elmira — Last: Baylis

4. DATE OF DEATH: Month: May — Day: 10, — Year: 1956

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 13, 1897

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Household duties

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Gillison Wanser

14. MOTHER'S MAIDEN NAME: Annie Gaskins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myasthenia Gravis
195X
DUE TO (b): Neoplasm of Thymus gland
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 9, 1956, to May 10, 1956, that I last saw the deceased alive on May 10, 1956, and that death occurred at 5: A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Glenn A. Drager M.D.

ADDRESS (Street, city or town, state): The Clinical Center

DATE SIGNED: May 10, 1956

PHYSICIAN'S NAME (Type): Glenn A. Drager,

The National Institutes of Health
Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/12/56

22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial

22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Dulin Funeral Home

ADDRESS:

24a. REC'D BY REGISTRAR DATE: 5/16/56

24b. REGISTRAR'S SIGNATURE: Mary Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05233

Reg. Dist. No. 24

5257

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): McCENEY AVENUE, BURNT MILLS HILLS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: McCENEY AVENUE, BURNT MILLS HILLS
e. IS RESIDENCE ON A FARM? Yes ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAUL — Middle VERNON — Last BETTERS

4. DATE OF DEATH: Month MAY — Day 12 — Year 1956

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/19/06

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Executive Vice-Pres. U.S. Conference of Mayors

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MORRIS, MINNESOTA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BURT BETTERS

14. MOTHER'S MAIDEN NAME: OLIVIA CHRISTENSEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW #2

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MRS. MYRA K. BETTERS, McCeney Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Bostwart M.D.
EXAMINER'S NAME (Type): FRANK J. BOSTWART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-12-56

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: 5/12/56
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CREMATORY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR — DATE: 5/15/56
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is to be cremated, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5258

Reg. Dist. No. 05234

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Alabama
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sumiton
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Myrna — Middle Loy — Last Blackston

4. DATE OF DEATH: Month May — Day 7, — Year 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 16, 1955

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 10 Days 21 — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jesse Blackston

14. MOTHER'S MAIDEN NAME: Leota Hagood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Congenital Heart Disease - Tetralogy of Fallot
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7540

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia secondary to decreased iron intake - food.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 6, 1956 to May 7, 1956 that I last saw the deceased alive on May 7, 1956, and that death occurred at 12:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward H Sharp M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): Edward H. Sharp, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 5/8/56

22c. NAME OF CEMETERY OR CREMATORY: Carbon Hill

22d. LOCATION (City, town, or county) (State): Birmingham, Alabama

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St., N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR DATE: 5-8-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5259

05235 2 14

Reg. Dist. No. 342

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: MONTG.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 8901 BROOKEVILLE Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8901 Brookeville Rd

3. NAME OF DECEASED (Type or print): First FANNIE Middle FRANCES Last BRADLEY

4. DATE OF DEATH: Month MAY Day 4 Year 1956

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 14 1879

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): PRINCE WILLIAM Co. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Fisher

14. MOTHER'S MAIDEN NAME: Ellen Hanes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Gladys Thomas — Address: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Hypertensive Cardio Renal
DUE TO (c): Disease with Edema

4427

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 17, 1948, to May 4, 1956, that I last saw the deceased alive on May 3, 1956, and that death occurred at 10:47 M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Webster Sewell M.D. ADDRESS (Street, city or town, state): Norbeck Rt 1 Silver Spring DATE SIGNED

PHYSICIAN'S NAME (Type): WEBSTER SEWELL

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5-9-56

22c. NAME OF CEMETERY OR CREMATORY: Church Cemetery

22d. LOCATION (City, town, or county) (State): Silver Spring Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry S Washington — ADDRESS: 467 N st N W

24a. REC'D BY REGISTRAR DATE: 5-10-56

24b. REGISTRAR'S SIGNATURE: Corrie Campbell — Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05236

5260

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL Silver Spring
d. STREET ADDRESS: Rt. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Maurice		Bready	May	2	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		11/18/67	88 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Farming-Owner	Maryland	USA

13. FATHER'S NAME: John Bready

14. MOTHER'S MAIDEN NAME: Katherine Baer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	Hospital Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Stomach	4/25/56
DUE TO (b)	Chronic Myocarditis	Years
DUE TO (c)	Nephritis	Years

593 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
	19					

21. I certify that I attended the deceased from 4/1/56, 19__, to 5/2/, 1956, that I last saw the deceased alive on 5/1/56, 1956, and that death occurred at 10:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. W. Bird M.D. ADDRESS (Street, city or town, state): Sandy Spring DATE SIGNED: 5/3/57

PHYSICIAN'S NAME (Type): J. W. Bird, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5-5-56	Rockville Union	Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: 5-4-56

24b. REGISTRAR'S SIGNATURE: Gertrude B Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5261

CERTIFICATE OF DEATH

05237

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4827 Leland St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First John — Middle Alexander — Last Brightwell

4. DATE OF DEATH: Month May — Day 11 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Nov. 21, 1884

9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Private Enterprise

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Brightwell

14. MOTHER'S MAIDEN NAME: Matilda McCormick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Un-kes known

17. INFORMANT: Elizabeth Schaefer — Address: 4827 Leland St. Chevy Chase, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Month
420.1
DUE TO
(b): Coronary Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Arteriosclerosis Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE, 1950, to 5-11, 1956, that I last saw the deceased alive on 5-11, 1956, and that death occurred at 6:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: P. P. Andrews — M.D. — ADDRESS (Street, city or town, state): 4301 Essex Ave N.W. — DATE SIGNED: 5-11-56

PHYSICIAN'S NAME (Type): P.P. ANDREWS — Washington D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-14-1956
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Prince Georges Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Robert A. Pumphrey Funeral Home Bethesda Md.

24a. REC'D BY REGISTRAR DATE: 5-11-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 4 may be ... by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5262 **CERTIFICATE OF DEATH**

105238

Reg. Dist. No. 217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 4 may be detached by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney — c. LENGTH OF STAY IN 1b: 1 week	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Woodfield
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County Gen. Hosp.	d. STREET ADDRESS: R.F.D. # 1, Gaithersburg — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Samuel Middle V. Lost Broadhurst	4. DATE OF DEATH: Month May Day 21 Year 19 56
5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Sept. 10,1866 — 9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operated threshing machines — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Penn. — 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George A. Broadhurst — 14. MOTHER'S MAIDEN NAME: Eliza Snowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT Address: Mrs Cramwell King, Gaithersburg, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerotic Heart Disease	2 yrs.
DUE TO	(b) With congestive heart failure +	10 Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO	(c) coronary thrombosis -	5 days, 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

420.0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No accident

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 7, 1953, to May 21, 1956, that I last saw the deceased alive on May 20, 1956, and that death occurred at 7 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M. McKendree Boyer M.D. — ADDRESS (Street, city or town, state): Damascus, Md. — DATE SIGNED: 5/24/56

PHYSICIAN'S NAME (Type): M. McKendree Boyer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: May 23,1956	22c. NAME OF CEMETERY OR CREMATORY: Bethesda	22d. LOCATION (City, town, or county) (State): Brownsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth — ADDRESS: Damascus, Md.		24a. REC'D BY REGISTRAR DATE: 5-23-56	24b. REGISTRAR'S SIGNATURE: Gertrude B Fowler

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05239

5263

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 44 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 9616 51st Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16-14-2

3. NAME OF DECEASED (Type or print): First: Anthony; Middle: William; Last: Brown

4. DATE OF DEATH: Month: May; Day: 16; Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 23, 1953

9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Brown

14. MOTHER'S MAIDEN NAME: Sarah Moss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): brain abscess — INTERVAL BETWEEN ONSET AND DEATH
20143
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): acute Leukemia
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 2, 1956, to May 16, 1956, that I last saw the deceased alive on May 16, 1956, and that death occurred at 12 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Mehran Goulian M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: May 16, 1956
PHYSICIAN'S NAME (Type): Mehran Goulian, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/17/56
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Sunset Memorial
22d. LOCATION (City, town, or county) (State): Spartanburg, S.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: Riverdale, Md.
24a. REC'D BY REGISTRAR DATE: MAY 23 1956
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5264 **CERTIFICATE OF DEATH**

05240 Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY 18 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clinical Center, NIH

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt #1 Clarksburg
d. STREET ADDRESS Rt. #1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First James Middle Walter Last Cabell

4. DATE OF DEATH Month 5 Day 19 Year 1956

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Sept. 15, 1946

9. AGE (In years last birthday) 9 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Cabell

14. MOTHER'S MAIDEN NAME MATTIE L Smith.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Naso pharynx ε
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) extension To Left Maxillae + obstruction of nares ε production of sinus
DUE TO (c) obstruction + frontal lobe abscess

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to May, 1956, that I last saw the deceased alive on 5-19, 1956, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE K. Lemore Yielding (OD) M.D. ADDRESS (Street, city or town, state) National Institutes of Health DATE SIGNED 5-19-56

PHYSICIAN'S NAME (Type) K. Lemore Yielding Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 22 May 1956

22c. NAME OF CEMETERY OR CREMATORY Upperville Cemetery

22d. LOCATION (City, town, or county) (State) Upperville, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. L. Burdette, Hyattstown, Maryland

24a. REC'D BY REGISTRAR DATE 5/22/56

24b. REGISTRAR'S SIGNATURE Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05241

5265 CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Westmoreland Hills
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5192 Albemarle St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Mont...
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westmoreland Hills
STREET ADDRESS (If rural give location) 5192 Albemarle St.

3. NAME OF DECEASED: (Type or Print) (First) BERNARD (Middle) ALBERT (Last) CHANDLER

4. DATE OF DEATH: (Month) MAY (Day) 28, (Year) 1956.

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec. 20-1884

9. AGE Last birthday: 71 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Internal Rev. Bur.

11. BIRTHPLACE (State or foreign country): New Gloucester, Maine

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew C. Chandler

14. MOTHER'S MAIDEN NAME: Sara E. Bean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Sara A. Chandler 5192 Albemarle St.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause (a)	Cardiac Collapse	5 MIN.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO	(Old) Coronary Thrombosis	2 YRS.
(c) DUE TO		

420.1
260X

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus (mild) — 3 YRS.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. ..., 1956 to May 28, 1956 that I last saw the deceased alive on May 24 1956 and that death occurred at 8:10 P.M. from the causes and on the date stated above.

SIGNATURE Raymond E. Reiger (Degree or title) M.D. ADDRESS 6940 Piney Branch Rd. Wash. 12, D.C. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation — DATE THEREOF 5-31-56 — NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery — LOCATION (City, town, or county) Prs. Geo. Co. (State) Md.

DATE REC'D BY LOCAL REGISTRAR May 31-1956 — REGISTRAR'S SIGNATURE Bessie M. Thompson

24. FUNERAL DIRECTOR Ike L. H. Hines Co ADDRESS 2901-14th St. N.W. Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05242

5266

CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-55

1. PLACE OF DEATH:
COUNTY Montgomery MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3316 Kensingt-Wheaton Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
STREET ADDRESS (If rural give location) 3316 Kensington-Wheaton Rd.

3. NAME OF DECEASED: (Type or Print) (First) Clara (Middle) Jane (Last) Clark

4. DATE OF DEATH: (Month) 5 (Day) 19 (Year) 1956

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 20, 1866

9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): London England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred F. Drew

14. MOTHER'S MAIDEN NAME: Elizabeth Malpus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT & ADDRESS: John D. Clark 3316 Kensington-Wheaton Rd.-Kensington Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

IMMEDIATE CAUSE (A) Congest. Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerosis Gentyl — yrs

DUE TO (C) Senility — yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture Rt. Femur — 2 wks

19A. DATE OF OPERATION: 5/1/56

19B. MAJOR FINDINGS OF OPERATION: Fracture Rt. Femur

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify Medical Examiner) ☐

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) Kw (County) (State) (NO accident)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/19/54, to 5/19/56, 19..., that I last saw the deceased alive on 5/18/56, 19..., and that death occurred at 12:03 A.M., from the causes and on the date stated above.

SIGNATURE AND ADDRESS M. D. Samuel Allen Kensington, Md. DATE SIGNED 5/19/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Transcd + Burial — DATE THEREOF 5-19-56 — NAME OF CEMETERY OR CREMATORY Northwood Cem — LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania

DATE REC'D BY LOCAL REGISTRAR 5-19-56 — REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR AND ADDRESS 2901 14th St N.W. S.H. Hines Co. Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5267

CERTIFICATE OF DEATH

Reg. Dist. No. 05243 296

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 2909 Harris Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: A. — Lost: Connell

4. DATE OF DEATH: Month: May — Day: 22 — Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 7, 1883

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman (Retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Connell

14. MOTHER'S MAIDEN NAME: Hanorah Mc Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes WWI (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Infarction of Colon with peritonitis — Interval between onset and death: 4 hours

DUE TO (b): Bronchopneumonia, both lungs — 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Tuberculosis, fibrocaseous, rt. lung, — 7 yrs.

0024

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Recurrent Epidermoid Carcinoma floor of mouth

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 16, 19 56, to May 22, 19 56, that I last saw the deceased alive on May 22, 19 56, and that death occurred at 1.00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John T. Binion M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes Of Health, Bethesda 14, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): John T. Binion, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/25/56

22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY

22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: MAY 25 1956

24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5268

05244

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY: 47-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3636-16th Street, N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: Pugsley — Last: Connery

4. DATE OF DEATH: Month: May — Day: 13, — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 12,1895

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months 8, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Administrative Assistant

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Senate

11. BIRTHPLACE (State or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Connery

14. MOTHER'S MAIDEN NAME: Annie Pugsley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Pancreas — INTERVAL BETWEEN ONSET AND DEATH
157x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 6, 1956, to May 13, 1956, that I last saw the deceased alive on May 13, 1956, and that death occurred at 9:14 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Claude E. Forkner Jr M.D.

PHYSICIAN'S NAME (Type): Claude E. Forkner, Jr., M. D.

ADDRESS (Street, city or town, state): The Clinical Center, The National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 5/14/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 5-15-56

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Nassau Knolls

22d. LOCATION (City, town, or county) (State): Nassau N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 16-56

24b. REGISTRAR'S SIGNATURE: Bernie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5269

CERTIFICATE OF DEATH

05245

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Dist. of Columbia
b. COUNTY Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 15
d. STREET ADDRESS 5425 Connecticut Ave N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mildred Middle M. Last Coughlin

4. DATE OF DEATH Month May Day 20 Year 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH JAN 17 1894
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Principal
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) unknown
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Daniel J. Coughlin
14. MOTHER'S MAIDEN NAME Margaret Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address
Mrs. Elva Wells (Sister) 5425 Conn. Ave. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH 4 months
203X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 12, 1956, to May 20, 1956, that I last saw the deceased alive on May 19, 1956, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN Sidney C. Cousins M.D. ADDRESS (Street, city or town, state) 3921 Langdrum St. Washington 20, D.C. DATE SIGNED 5/22/56

PHYSICIAN'S NAME (Type) SIDNEY C. COUSINS 3921 TUNLAW ST. NW D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May 22, 1956
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery
22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. ADDRESS 2901 14th St. N.W. Washington 9, D. C.
24a. REC'D BY REGISTRAR DATE 5-22-56
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5270

05246

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 34 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, NIH

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Taswell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bandy
d. STREET ADDRESS: Route # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

83x3

3. NAME OF DECEASED (Type or print): First: Cloy; Middle: May; Last: Crouse

4. DATE OF DEATH: Month: May; Day: 26; Year: 1956

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 15 Sept. 1908

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Cochran

14. MOTHER'S MAIDEN NAME: Cynthia Asbury

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Not available

17. INFORMANT: The Medical Record, Clinical Center, NIH
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute & Chronic Congestive Heart Failure & Hypertrophy — INTERVAL BETWEEN ONSET AND DEATH: 5/26/56

410 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardiac Cirrhosis; Metabolic & Electrolytic Embalance. — 5/21/56

DUE TO (c): Rheumatic Heart Disease (Mitral Stenosis & Tricuspid Insf.) — Childhood

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pyelonephritis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 22 April, 1956, to 26 May, 1956, that I last saw the deceased alive on 26 May, 1956, and that death occurred at 10.45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward H Sharp M.D. — ADDRESS (Street, city or town, state): 120 Center Drive Bethesda, Maryland — DATE SIGNED: 5/27/56

PHYSICIAN'S NAME (Type): Edward H. Sharp, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): removal

22b. DATE THEREOF: 5/28/56

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): Richlands, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., 2901 14th St. N.W.
ADDRESS: Wash, D.C.

24a. REC'D BY REGISTRAR DATE: 5-30-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5271

CERTIFICATE OF DEATH

05247

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Travilah
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Travilah
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes; Middle: M.; Last: CROWN

4. DATE OF DEATH: Month: May; Day: 17; Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-14-1900

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months: 8; Days: 3
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clarence Beane

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Jessie Crown, Address: Son Rt. 1 Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEPATIC COMA GENERALIZED METASTASIS — INTERVAL BETWEEN ONSET AND DEATH: 24 HOURS
DUE TO
(b): DIABETES MELLITUS — 5 MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): CARCINOMA OF BRONCHI — 5 MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JANUARY 11, 19 56 to MAY 17, 19 56, that I last saw the deceased alive on MAY 17, 19 56, and that death occurred at 10:45 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John D Rosenberger M.D. — ADDRESS (Street, city or town, state): 310 W. MONTGOMERY Ave. Rockville, MD — DATE SIGNED: MAY 17 56

PHYSICIAN'S NAME (Type): Gordon S. Rosenberger, M. D. — 310 W. Montg. Ave. Rockville, Md. 5/17/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/20/1956

22c. NAME OF CEMETERY OR CREMATORY: Forest Oak

22d. LOCATION (City, town, or county) (State): Gaithersburg Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda

24a. REC'D BY REGISTRAR DATE: 5/21/56

24b. REGISTRAR'S SIGNATURE: Laurel Krastop

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05248

5272

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Philomena Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of — b. COUNTY: Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3351 Tennyson St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BEATRICE — Middle J — Last DANE

4. DATE OF DEATH: Month May — Day 3 — Year 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 26, 1867
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months 7 — Days 7
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Jodon
14. MOTHER'S MAIDEN NAME: Sarah Glover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Ruth Beatrice Dane — Address: 3351 Tennyson St. N.W. Wash DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: unstated

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral arteriosclerosis - senile; gen. arteriosclerosis; pneumonia, lobular, bilateral, hypostatic, acute

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1952, to May 3, 1956, that I last saw the deceased alive on April 19, 1956, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas E. Curtin M.D. — ADDRESS (Street, city or town, state): 900 17th St N.W. — DATE SIGNED: May 3 1956

PHYSICIAN'S NAME (Type): Thomas E. Curtin MD — Wash D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 5-3-56
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 5-4-56
24b. REGISTRAR'S SIGNATURE: Gertrude B Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5273

CERTIFICATE OF DEATH

05249

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 5 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY: 47x-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2347 Ashmeade Place, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Kyle — Last: DAVENPORT

4. DATE OF DEATH: Month: May — Day: 6 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8 March 1883

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Merchantile

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Travis DAVENPORT

14. MOTHER'S MAIDEN NAME: Velle ANDREWS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): — —

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Mrs. Lena DAVENPORT (Wife) Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Pulmonary embolism — 10 hrs

DUE TO (c): Atherosclerosis, widespread — 20+ yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary sclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 May, 1956 to 6 May, 1956 that I last saw the deceased alive on 6 May, 1956, and that death occurred at 6:40P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm B Ingram M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 5/7/56

PHYSICIAN'S NAME (Type): William B. Ingram, CDR, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10 May 1956

22c. NAME OF CEMETERY OR CREMATORY: Oakwood Cemetery

22d. LOCATION (City, town, or county) (State): Spartanburg, South Carolina

23. FUNERAL DIRECTOR'S SIGNATURE: Robt. A. Pumphrey — ADDRESS: Bethesda, Md. — R.A. Pumphrey Funeral Home, 7557 Wisc.Ave.,

24a. REC'D BY REGISTRAR — DATE: 5-7-56

24b. REGISTRAR'S SIGNATURE: Thos. E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 4 may be ... by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5274

CERTIFICATE OF DEATH

05250

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 11 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, NNMC, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1239 45th Place S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Jacob — Last: DAVIES

4. DATE OF DEATH: Month: May — Day: 21 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 24 March 1875

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: Mariner (Retired)

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Jacob DAVIES

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): WW-I — (If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Alice G. WEICKHARDT (Step-Daughter) — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Infarction, Myocardial, Acute — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes
420.1
DUE TO (b): Atherosclerosis, Coronary arteries — years(?)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral edema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10 May, 1956, to 21 May, 1956, that I last saw the deceased alive on 21 May, 1956, and that death occurred at 6:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. B. Ingram M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 5/21/56

PHYSICIAN'S NAME (Type): William B. INGRAM, CDR, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-23-56

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros 1661 - 2nd Place Rd S E — ADDRESS: SIMMONS BROS, ~~2007 Nichols Ave.~~, S.E. Wash, DC

24a. REC'D BY REGISTRAR DATE: 5-21-56

24b. REGISTRAR'S SIGNATURE: Mary E. Darnell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 4 may be ... by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5275

Item 18 Film G198 6-8-56 ams

CERTIFICATE OF DEATH

05251

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: ½ hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville, R.F.D.
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Isabel; Middle: ; Last: Davy

4. DATE OF DEATH: Month: 5 — Day: 22 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-21-90

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Martha McKnight

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 061-20-6876A

17. INFORMANT: Address: Mrs Daniel Callahan, Poolesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — 420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart Disease
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 22 1956, to May 22 1956 that I last saw the deceased alive on May 22, 1956, and that death occurred at 6 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George Sharpe M.D. ADDRESS (Street, city or town, state): 10644 Connecticut ave DATE SIGNED:

PHYSICIAN'S NAME (Type): George Sharpe — Kensington, md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-24-56

22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

22d. LOCATION (City, town, or county) (State): Rockville - md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm. B. Hilton, Barnesville, md.

24a. REC'D BY REGISTRAR DATE: 5/28/56 Barnesville

24b. REGISTRAR'S SIGNATURE: Charles W. Elgin per [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5233 **CERTIFICATE OF DEATH**

Reg. Dist. No. 05252 2-23

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK
c. LENGTH OF STAY IN 1b 6 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE WASH. DC b. COUNTY D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC 12
d. STREET ADDRESS 6622 5th St. NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First WILLIAM Middle JAMES Last DEMING

4. DATE OF DEATH Month MAY Day 2 Year 1956

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 11-16-75

9. AGE (In years last birthday) 81 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOV. EMP.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) NEW YORK

12. CITIZEN OF WHAT COUNTRY? AMERICA

13. FATHER'S NAME ARTHUR DEMING

14. MOTHER'S MAIDEN NAME ADELAID AVERY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address ANNE L. DEMING, 6622 5th ST. N.W. DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH 3 wks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive cardiovascular renal disease — 10 yrs
DUE TO
(c)

442X
016X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Intercostal Left Pleurisy & adhesions

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1947, 19__, to May 2, 1956, that I last saw the deceased alive on May 2, 1956, and that death occurred at 5:33 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE Kenneth F. Laughlin M.D. ADDRESS (Street, city or town, state) 934 Ellsworth Dr Silver Spring DATE SIGNED 5-3-56

PHYSICIAN'S NAME (Type) KENNETH F. LAUGHLIN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF May 5, 1956

22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery

22d. LOCATION (City, town or county) Washington (State) D.C.

23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Waller ADDRESS 254 Carroll St. N.W. Takoma Park, Md.

24a. REC'D BY REGISTRAR DATE 5/4/56

24b. REGISTRAR'S SIGNATURE J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5276

CERTIFICATE OF DEATH

05253 7/7

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: Two 20da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sharon Chronic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridge
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Anna — Middle E. — Last Dent

4. DATE OF DEATH: Month May — Day 22 — Year 1956

5. SEX: F

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Feb 16, 1878

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): store keep

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): St. Mary's County

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Green

14. MOTHER'S MAIDEN NAME: Anna Wompkin-

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs-Herman Mather — Address: Beltsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Dehydration + Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b): For advanced Ca of Colon (metast) 4 yrs
DUE TO
(c):

153X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr 2, 1956, to May 22, 1956, that I last saw the deceased alive on 22 May, 1956, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John B Ziegler M.D. — ADDRESS (Street, city or town, state): Olney Md — DATE SIGNED: 22 May 56

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/24/1956

22c. NAME OF CEMETERY OR CREMATORY: St. GEORGE'S EPISCOPAL VALLEY LEE

22d. LOCATION (City, town, or county) (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: CHARLES J. MATTINGLY — ADDRESS: LEONARDTOWN MD.

24a. REC'D BY REGISTRAR DATE: 5/22/56

24b. REGISTRAR'S SIGNATURE: Alan D. Hammond

Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5277

CERTIFICATE OF DEATH

05254

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 6 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ammons Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laytonsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Idella — Middle: Prather — Last: Diggs

4. DATE OF DEATH: Month: May — Day: 11 — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 28, 1872

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Levi Prather

14. MOTHER'S MAIDEN NAME: Susan Simpson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: George Diggs Gaithersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage #4 — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c): Hypertensive Cardiorenal Disease

4428

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 30, 19 56 to May 11, 19 56 that I last saw the deceased alive on May 10, 19 56, and that death occurred at 10:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Webster Sewell M.D. — ADDRESS (Street, City or town, state): Norbeck RFD 1 — DATE SIGNED: 5-13-56

PHYSICIAN'S NAME (Type): WEBSTER SEWELL — Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/14/56

22c. NAME OF CEMETERY OR CREMATORY: Brooke Grove

22d. LOCATION (City, town, or county) (State): Laytonsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: May 15, 56

24b. REGISTRAR'S SIGNATURE: Alexander G. Cook

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05255

5234 **CERTIFICATE OF DEATH**

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 307 Manor Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Francis — Last: Donovan

4. DATE OF DEATH: Month: May — Day: 12 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-7-87

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): cab driver

10b. KIND OF BUSINESS OR INDUSTRY: American Cab. Co

11. BIRTHPLACE (State or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY?: America

13. FATHER'S NAME: John Donovan

14. MOTHER'S MAIDEN NAME: Anna Crowley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 578-01-9016

17. INFORMANT: Mrs. Sylvia Donovan — Address: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Esophagus — INTERVAL BETWEEN ONSET AND DEATH: 9 mo.

150X

DUE TO

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1955, to May 12, 1956, that I last saw the deceased alive on May 12, 1956, and that death occurred at 9:30 P M from the causes and on the date stated above.

ACTUAL SIGNATURE: J. M. Whitlock M.D. — ADDRESS (Street, city or town, state): Washington Sanitarium — DATE SIGNED: May 13/56

PHYSICIAN'S NAME (Type): J. M. WHITLOCK

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: May 16, 1956

22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY

22d. LOCATION (City, town, or county) (State): SUITLAND, PR GEO. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: Takoma Park 12 — 254 Carroll St N.W. D.C

24a. REC'D BY REGISTRAR DATE: 5/14/56

24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05256

5278

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood R #1
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mt. Zion

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood R #1
d. STREET ADDRESS: Mt. Zion
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah; Middle: Emma; Last: Dorsey

4. DATE OF DEATH: Month: May; Day: 30,; Year: 1956

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 30, 1878

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel Kelly

14. MOTHER'S MAIDEN NAME: Hester Harding

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1½ days
331X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
260X

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Frank J. Broschart — 5-31-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/2/56
22c. NAME OF CEMETERY OR CREMATORY: Locus Chapel
22d. LOCATION (City, town, or county) (State): Simpsonville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: 6-4-56
24b. REGISTRAR'S SIGNATURE: Gertrude B Lawler

TO DE[illegible] MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute [illegible] cate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5279

CERTIFICATE OF DEATH

05257.
Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church
d. STREET ADDRESS: 304 Sycamore St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: Veronica — Last: DREWES

4. DATE OF DEATH: Month: May — Day: 29 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1 Feb. 1904

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Patrick Brennen

14. MOTHER'S MAIDEN NAME: Johanna Brennen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): — —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: (Son) Albert J. DREWES (Same As #2)
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intra Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 Days
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Atherosclerosis, Widespread — Indefinite
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 26 May, 1956, to 29 May, 1956, that I last saw the deceased alive on 29 May, 1956, and that death occurred at 7:00P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R R Brandon, Lt. MC USNR M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, NNMC, Bethesda, Md. — DATE SIGNED: 5/30/56

PHYSICIAN'S NAME (Type): R.R. BRANDON, LT, MC, USNR — U.S. Naval Hospital, NNMC, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1 June 1956
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Arlington, Va.
Fitzgerald Funeral Home 3245 Wilson Blvd.

24a. REC'D BY REGISTRAR DATE: 5-30-56

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05258

Reg. Dist. No. 218

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND — 5280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizebeth — Middle: Emberry — Last: Dumhart

4. DATE OF DEATH: Month: May — Day: 21 — Year: 19 56

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/14/1870

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard Dumhart

14. MOTHER'S MAIDEN NAME: Ruth Burriss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Clarence Nicholson. Bethedda Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed.
DUE TO (b): Chronic heart desease — 2 yrs.
DUE TO (c):

4343
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED — While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5/21/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-22-56
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak
22d. LOCATION (City, town, or county) (State): Gaithersburg. Md,

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. ADDRESS: Gaithersburg. Md,

24a. REC'D BY REGISTRAR DATE: May 23-56
24b. REGISTRAR'S SIGNATURE: Almeda G. Cook

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute [illegible] cate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 10a: film GI98 6-4-56L 5281

CERTIFICATE OF DEATH

Reg. Dist. No. 05259 17

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 2 mo. in Md.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sharon Chronic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1013 De Beck Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rupert; Middle; Last Ebner

4. DATE OF DEATH: Month May; Day 13; Year 1956

5. SEX: Male

6. COLOR OR RACE: W-

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 27 1885

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months 4; Days 16
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BANKER BAKER

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Vienna Austria

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Rupert Stengal

14. MOTHER'S MAIDEN NAME: Anna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 488-01-7464

17. INFORMANT: Mrs. Anna Colby Address: 1013 De Beck Drive Rockville - Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Sub-Arachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Gen. Arteriosclerosis + Hypertension — 10 yrs

DUE TO (c): Cardio-Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 MAR 56 to 13 MAY 56 that I last saw the deceased alive on 13 MAY 56, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Bosley Ziegler M.D. ADDRESS (Street, city or town, state): Olney, Md. DATE SIGNED: 13 MAY 56

PHYSICIAN'S NAME (Type): JOHN B. ZIEGLER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
22b. DATE THEREOF: 5-14-56
22c. NAME OF CEMETERY OR CREMATORY: Missouri Cemetery
22d. LOCATION (City, town, or county) (State): St. Louis Missouri

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 5-18-56
24b. REGISTRAR'S SIGNATURE: Gertrude B Fawley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5282

Reg. Dist. No. 05269

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 2 wks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2311 Church Hill Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pa b. COUNTY Delaware
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Yeadon
d. STREET ADDRESS 960 Mer. Dale Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Louis	Lee	Emper	May	17	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		7-20-1884	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Produce buyer		Pa	U S C

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Emper	Susan Caravano

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Leona Carson (daughter)	2311 Church Hill Rd Silver Spring Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion	Sudden
DUE TO (b)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

I 20.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Frank J Bioschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5-17-56

EXAMINER'S NAME (Type) FRANK J. BIOSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	5/18/56	Holy Cross Cem	Darby, Penn.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Geraldi Funeral Home	5/22/56	Frances Potter

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... necessary, please exe... cute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05261

5283

CERTIFICATE OF DEATH

Reg. Dist. No. 21 b

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 80 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Clinical Center, National Inst. of Health

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Market
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Cleo; Middle: Grace; Last: Eyler

4. DATE OF DEATH: Month: May; Day: 26; Year: 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 28 June 1916

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ray Stevens

14. MOTHER'S MAIDEN NAME: Bessie Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-14-9344

17. INFORMANT: The Medical Record, Clinical Center
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days
DUE TO
(b): Malignant Melanoma — 2 yrs.
DUE TO
(c):

190X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 March, 1956, to 26 May, 1956, that I lost saw the deceased alive on 26 May, 1956, and that death occurred at 6.00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard D. Fitz M.D.
ADDRESS (Street, city or town, state): 3 Pooks Hill Rd. Bethesda, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Richard D. Fitz

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/29/56
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Rocky Hill
22d. LOCATION (City, town, or county) (State): Mt. Woods Ivars Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. C. Barton
ADDRESS: Walkersville, md

24a. REC'D BY REGISTRAR DATE: JUN 1 1956
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

, 5235

CERTIFICATE OF DEATH

05262

Reg. Dist. No. 223

1

M

17

75

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: —
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia 47 X-3
d. STREET ADDRESS: 7429 Columbia Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida; Middle: May; Lost: Fischer
4. DATE OF DEATH: Month: May; Day: 30; Year: 1956
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-5-83
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: Am.

13. FATHER'S NAME: John Wilson
14. MOTHER'S MAIDEN NAME: Emma O. Mangum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Hospital Records

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Tamponade — INTERVAL BETWEEN ONSET AND DEATH: Terminal

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Atherosclerosis + Stenosis — Years ?

DUE TO (c): Cardio-Vasc heart disease — Years ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-25, 1956, to 5-30, 1956, that I last saw the deceased alive on 5-29, 1956, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A Hare M.D. — ADDRESS (Street, city or town, state): Takoma Park Md — DATE SIGNED: 5/30/56

PHYSICIAN'S NAME (Type): Robert A. Hare — Takoma Park Md — 5/30/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/2/56
22c. NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery
22d. LOCATION (City, town, or county) (State): Beltsville, Marylsnd

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Wines Co — ADDRESS: 2901 14th St., N.W. Washington, D.C.

24a. REC'D BY REGISTRAR DATE: 6/1/56
24b. REGISTRAR'S SIGNATURE: J. Ethan Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06312

Reg. Dist. No. 214

5284

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8242 Georgia Ave.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47X.3
d. STREET ADDRESS: 1414 UNDERWOOD STREET, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DR. SAMUEL — Middle — Last: FISHMAN

4. DATE OF DEATH: Month: MAY — Day: 30 — Year: 19 56

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 6, 1908

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHYSICIAN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS FISHMAN

14. MOTHER'S MAIDEN NAME: HANNAH HENDEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mrs. Tillie Fishman, 1414 Underwood St., N.W. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-30-56

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 1, 1956
22c. NAME OF CEMETERY OR CREMATORY: Adas Israel Cemetery
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: B. Wayansky & Son 3501-14 St. NW
24a. REC'D BY REGISTRAR DATE: 6/5/56
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute it to date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05263

5285

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH

COUNTY Montgomery — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda

LENGTH OF STAY (in this place) 2 1/4 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Montgomery

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda

STREET ADDRESS (If rural give location) 5202 Westwood Drive

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Frederick (Last) Foshag

4. DATE OF DEATH (Month) May (Day) 21 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		Mar. 17, 1894	62 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Scientist	US Govt	New York	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William F. Foshag	Eva Reigler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		None	Merle Foshag 5202 Westwood Drive

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Malignant fibroblastoma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Coronary-hypertensive heart dis. — 4 yrs

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Essential hypertension

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 1952 ....., to 5/21 ....., 19 56 ....., that I last saw the deceased alive on 5/16/ ....., 19 56 ....., and that death occurred at 7:00 A.M., from the causes and on the date stated above.

SIGNATURE Richard A. Read M.D. **ADDRESS** (Street, city, town, state) 900 - 17th St., N.W. **DATE SIGNED** 5/21/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	5/23/1956	Cedar Hill Crematory	Suitland, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
5-25-56	Bessie M. Thompson	Joseph Gawler's Sons WASH. D.C. by J.E. Hamm	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5250

CERTIFICATE OF DEATH

05264

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 502 Dean Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 502 Dean Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle JEWETT — Last FOSTER

4. DATE OF DEATH: Month May — Day 18, — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 22-1905

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months 2 — Days 26
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Sta. Attend.

10b. KIND OF BUSINESS OR INDUSTRY: Gas Station

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Foster

14. MOTHER'S MAIDEN NAME: Nanette Jewett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 578-03-3267

17. INFORMANT: W.B. Markham Stepson — Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary occlusion & Myocardial Infarct. — 1 week
DUE TO
(c) Coronary arteriosclerosis — Indef.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/1/56 to 5/18/56, that I last saw the deceased alive on 5/18/56, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen M. Jones M.D. — ADDRESS (Street, city or town, state): Rockville, Md — DATE SIGNED: 5/19/56

PHYSICIAN'S NAME (Type): Stephen M. Jones — Rockville, Md — 5/19/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-21-56
22c. NAME OF CEMETERY OR CREMATORY: George Washington Cem
22d. LOCATION (City, town, or county) (State): Hyattsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE 5/21/56

24b. REGISTRAR'S SIGNATURE: Laurel Kraglorp for E.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5236 **CERTIFICATE OF DEATH**

05265

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Takoma Park
c. LENGTH OF STAY IN 1b: 6 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 75 Washington San+Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia. b. COUNTY: 47 x 3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2801 31st St. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mr Robert Middle Berle Last Frazier

4. DATE OF DEATH: Month May Day 12 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 26 1905

9. AGE (In years / lost birthday): 50 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Health Educ. + Welfare Dpt. (clerk)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hover L. Frazier

14. MOTHER'S MAIDEN NAME: Luella Graham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.#2.

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Hospital records -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Thrombophlebitis — 4 hrs 45 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma w/ bladder

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 5/1 1956, to 5/12 1956, that I last saw the deceased alive on 5/12 1956, and that death occurred at 4:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur J. Wilets M.D. — ADDRESS (Street, city or town, state): 909 Pershing Drive, Silver Spring, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Arthur J. Wilets

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 5/15/56

22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl. Cem.

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. ADDRESS: 2901-14th St. NW Washington, D. C.

24a. REC'D BY REGISTRAR DATE: 5/14/56

24b. REGISTRAR'S SIGNATURE: Clifton Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5286

CERTIFICATE OF DEATH

05266

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4hr. 34 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, NNMC, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4525 Buchanan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16-15-2.

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Anna; Last: GIBBARD

4. DATE OF DEATH: Month: May; Day: 23; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-23-56

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months; Days; IF UNDER 24 HRS.: Hours: 4; Min.: 34

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Bethesda, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Foy Wallace GIBBARD

14. MOTHER'S MAIDEN NAME: Catherine Virginia CARTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: (Father) Foy Wallace GIBBARD (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
776x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 May, 1956, to 23 May, 1956, that I last saw the deceased alive on 23 May, 1956, and that death occurred at 9:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J.W. Stohlman III (M.C.) USNR, M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 5-24-56

PHYSICIAN'S NAME (Type): J.W. STOHLMAN, III, LT, MC, USNR — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-26-56

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: L. Fiddler — ADDRESS: Hyattsville, Md.
Francis GASCH'S Sons 4739 Baltimore Ave.,

24a. REC'D BY REGISTRAR DATE: 4-23-56

24b. REGISTRAR'S SIGNATURE: Mary E. Donnelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2051294 X VO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8: & 9: Film G198
6/6/56 dmr. 5287

CERTIFICATE OF DEATH

Reg. Dist. No. 05267

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7810 Moreland Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 7810 Moreland Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY — Middle WILLIAM — Last GIERSBERG

4. DATE OF DEATH: Month May — Day 25 — Year 19 56

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-11-1878
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months 5, Days 14 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gustav Giersberg
14. MOTHER'S MAIDEN NAME: Anna Yanke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — If yes, give war or dates of service: WW I
16. SOCIAL SECURITY NO.: 058-04-4372
17. INFORMANT: Kathryn S.Power, Dau. Item 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Starvation - Coma — INTERVAL BETWEEN ONSET AND DEATH: 2 Weeks
DUE TO
(b): Cerebral-Vascular Accident — 2 weeks - 1st Attack 1952.
DUE TO
(c): Cardio Vascular Disease — 20 yrs.

422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma - Prostate. & Metastis - to Pelvis. Spine. Lungs —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 Jan, 1952 to 25 May, 1956, that I last saw the deceased alive on 14 May, 1956, and that death occurred at 7 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John G. Ball, M.D. — ADDRESS (Street, city or town, state): 7936 Georgetown Rd. — DATE SIGNED: 25 May 56.
PHYSICIAN'S NAME (Type): John G. Ball — Bethesda 14 Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
22b. DATE THEREOF: 5-26-56
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
22d. LOCATION (City, town, or county) (State): Pleasantville N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 5-28-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05268

5288

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9213 Columbia Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle William Last Gill

4. DATE OF DEATH: Month May Day 12 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 28 1906

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LAWYER

10b. KIND OF BUSINESS OR INDUSTRY: Private Practice

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wirt Alvin Gill

14. MOTHER'S MAIDEN NAME: Marcy Stevens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-09-3763

17. INFORMANT: Mrs. Ruth R. Gill - wife
Address: 9213 Columbia Blvd Silver Spring Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatitis — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
583X
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 10, 1956 to May 12, 1956, that I last saw the deceased alive on May 12, 1956, and that death occurred at 12:42 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Marion Bankhead M.D. — ADDRESS (Street, city or town, state): 9241 Col. Blvd. Silver Spring, Md. — DATE SIGNED: 5/14/56

PHYSICIAN'S NAME (Type): J. Marion Bankhead

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 15, 1956

22c. NAME OF CEMETERY OR CREMATORY: Rockville Union Cemetery

22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Warner C. Pumphrey — ADDRESS: Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: 5/16/56

24b. REGISTRAR'S SIGNATURE: Mrs. Bessie Thompson

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5289

CERTIFICATE OF DEATH

05269

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 11mo, 9days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SHARON CHRONIC HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton, Silver Spring
d. STREET ADDRESS: 10406 Ga. Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillie; Middle: ; Last: Gleason

4. DATE OF DEATH: Month: May; Day: 31; Year: 1956

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 4, 1870

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Charles W. Cramer

14. MOTHER'S MAIDEN NAME: Martha Biggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs Tomagni, 10406 Ga. Ave Wheaton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Stomach - far advanced gen. metastasis — INTERVAL BETWEEN ONSET AND DEATH: 3 YEARS
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 22, 1955, to May 31, 1956, that I last saw the deceased alive on May 24, 1956, and that death occurred at 6:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Bosley Ziegler M.D.
ADDRESS (Street, city or town, state): Olney Md
DATE SIGNED: May 31, 1956

PHYSICIAN'S NAME (Type): John Bosley Ziegler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/2/1956
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. P. Hines Co.
ADDRESS: 2901-14 St NW Wash. D.C.

24a. REC'D BY REGISTRAR DATE: 5-31-56
24b. REGISTRAR'S SIGNATURE: Gertrude B Landon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5290

CERTIFICATE OF DEATH

Reg. Dist. No. 05250

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District Of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 520 4th St., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy; Middle:; Last: GOODINE

4. DATE OF DEATH: Month: May; Day: 12; Year: 1956

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10 May 1956

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: Days: 2
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Infant

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert GOODINE, Jr.

14. MOTHER'S MAIDEN NAME: Lois Gladys ADAMS (S

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: (Mother) Lois G. GOODINE (Same As #2)
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PERICARDIAL EFFUSION — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS
DUE TO
(b): INTERVENTRICULAR SEPTAL DEFECT — 10 DAYS
DUE TO
(c):

754.2

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10 May, 1956, to 12 May, 1956, that I last saw the deceased alive on 12 May, 1956, and that death occurred at 3:07P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J.W. Stolhman III M.D.
ADDRESS (Street, city or town, state): U.S. Naval Hospital, NNMC, Bethesda, Md.
DATE SIGNED: 5-14-56

PHYSICIAN'S NAME (Type): J.W. STOLHMAN, III, LT, MC, USN — U.S. Naval Hospital, NNMC, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-16-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE:
ADDRESS: CHINN Funeral Home 2605 Seminary Rd. Arl. Va.

24a. REC'D BY REGISTRAR DATE: 5-14-56
24b. REGISTRAR'S SIGNATURE: Emmy E. Crassella

2051191XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05271

Reg. Dist. No. 216

Items 18,20,21 Film G196 6-6-56 ans

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5420 Goldsboro Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: Goldsboro Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eunice — Middle: C. — Last: Goodwin

4. DATE OF DEATH: Month: May — Day: 16 — Year: 1956

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 19,1924

9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months: 8 Days: 27
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel A. Clayton

14. MOTHER'S MAIDEN NAME: Amye Purcell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: yes

17. INFORMANT: Leo Goodwin- Item # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carbon monoxide poisoning
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

973.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Found dead in garage with door closed, motor had been running.

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.

EXAMINER'S NAME (Type): Frank J, Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 5/17/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-19-56

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or county) (State): Prince George, Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey-Bethesda, Md.
ADDRESS:

24a. REC'D BY REGISTRAR DATE: 5-21-56

24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... necessary, please exe... cate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral ... Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5292

CERTIFICATE OF DEATH

05272

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9518 Colesville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leopold — Middle: J. — Last: Guggenberger

4. DATE OF DEATH: Month: 5 — Day: 25 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/31/1879

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Salesman

11. BIRTHPLACE (State or foreign country): N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leopold Guggenberger

14. MOTHER'S MAIDEN NAME: Dorothea Kumpf.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 220-26-4337

17. INFORMANT: Emily D. Rinderle — Address: Bronx N.Y.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years
DUE TO
(b): Nephritis — 4 Years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 1942, to May 25, 1956, that I last saw the deceased alive on May 14, 1956, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John N. Andrews M.D. — ADDRESS (Street, city or town, state): 9601 Colesville Rd — DATE SIGNED: 5-25-56

PHYSICIAN'S NAME (Type): John N. Andrews M.D. Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/28/56

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn

22d. LOCATION (City, town, or county) (State): Bronx N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co — ADDRESS: 1400 Chapin St NW

24a. REC'D BY REGISTRAR DATE: 5/29/56

24b. REGISTRAR'S SIGNATURE: Frances [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

JUN 4 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05273

CERTIFICATE OF DEATH

5251 Reg. Dist. No.

1. PLACE OF DEATH

COUNTY: Montgomery — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville

LENGTH OF STAY (in this place): 4 mo

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Congressional Manor Sanit. 12201 Rockville Pike

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: D.C. COUNTY:

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

STREET ADDRESS (If rural give location): 4304 18th St. N.W.

3. NAME OF DECEASED (Type or Print): (First) Gertrude (Middle) (Last) Gustafson

4. DATE OF DEATH: (Month) May (Day) 11 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
					Months	Days	Hours	Min.
female	white	married	3/3/1866	90 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at home	Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Kelley	unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no		-	Sanitarium records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE(S) DUE TO (B) Cardiac Decompensation — 4 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic Heart Disease — 7 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus — 3 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
	None	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
None M.		

22. I hereby certify that I attended the deceased from July 24, 1944, to May 11, 1956, that I last saw the deceased alive on May 10, 1956, and that death occurred at 3:20 A.M., from the causes and on the date stated above.

SIGNATURE: Glen Pincock M.D. ADDRESS (Street, city, town, state): 1944 Seminary Rd Silver Spg Md DATE SIGNED: 5/11/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	5/14/56	Union Cemetery	Leesburg, Virginia

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE 10/14/56	Laurell H. Kraglorp	2901 14th St. N.W., The S.H.Hines Co. Wash. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5237

05274

CERTIFICATE OF DEATH

Reg. Dist. No. 273

1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY 47x-3

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 11 hours.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital
d. STREET ADDRESS 8 Walnut St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Mabel Middle Florence Last Hackett
4. DATE OF DEATH Month 5 Day 12 Year 1956

5. SEX Female
6. COLOR OR RACE Cauc.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-16-02
9. AGE (In years last birthday) 54 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) ~~Kansas~~ Chicago, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Stokke
14. MOTHER'S MAIDEN NAME Maria Ryerson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Washington Sanitarium & Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest with myocardial failure — INTERVAL BETWEEN ONSET AND DEATH 2 hrs 40 min

584X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Post-operative shock — 30 min

DUE TO (c) Hypertensive vascular disease — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Acute Cholecystitis & Cholelithiasis GB removed 5-11-56 at 6:30 P.M.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 19 35 to 5/12 19 56, that I last saw the deceased alive on 5/12/1956, 19__, and that death occurred at 12:10 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Frank L. Milliman M.D. ADDRESS (Street, city or town, state) 2731 Connecticut Ave DATE SIGNED 5/13/56

PHYSICIAN'S NAME (Type) Frank L Milliman Washington D C

22a. BURIAL, CREMATION, REMOVAL (Specify) Transit Burial
22b. DATE THEREOF May 15, 1956
22c. NAME OF CEMETERY OR CREMATORY Beachgrove Cemetery
22d. LOCATION (City, town, or county) (State) Muncie Indiana

23. FUNERAL DIRECTOR'S SIGNATURE A. Arthur Walters ADDRESS 254 Carroll St NW DC
24a. REC'D BY REGISTRAR DATE 5/14/56
24b. REGISTRAR'S SIGNATURE J. Arthur Wedd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5293

CERTIFICATE OF DEATH

~~05274~~ 05275

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montg — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montg

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg

c. LENGTH OF STAY IN 1b: 12yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

d. STREET ADDRESS: 7- Montg. Ave

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Emily	W. Lyddane	Hall	May	7	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Sept 21-1884	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Home Work	Montg Co. Md,	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William J. Williams	Elizabeth A Schaeffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		Virginia Darby. Gaithersburg. Md,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Pancreas

DUE TO
(b): with Generalized Metastasis

DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

157X

INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-1, 1956, to 5-7, 1956, that I last saw the deceased alive on 5-6, 1956, and that death occurred at 2 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: F J Broschart M.D. ADDRESS (Street, city or town, state): Gaithersburg md DATE SIGNED: 5-8-56

PHYSICIAN'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5-10-56	Monocacy	Beallsville. Md,

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Ernest C. Gartner,	Gaithersburg.Md,	May 9-56	Arnold L. Cooke

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOS

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5294

CERTIFICATE OF DEATH

05276

Reg. Dist. No. 214

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: MONTGOMERY — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 9525 THORNHILL ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: MARYLAND — COUNTY: MONTGOMERY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

STREET ADDRESS (If rural give location): 9525 THORNHILL ROAD

3. NAME OF DECEASED (Type or Print): (First) FANNIE (Middle) M (Last) HALLEY

4. DATE OF DEATH: (Month) MAY (Day) 19 (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE	WIDOWED	JULY 1, 1867	88 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER - RETIRED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES JAMES

14. MOTHER'S MAIDEN NAME: SUSAN HUTCHISON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 577-18-6743-D

17. INFORMANT & ADDRESS: Mr. Eugene Halley, 9525 Thornhill Rd. Silver Spring, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4437 IMMEDIATE CAUSE (A): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSE(S) DUE TO (B): Hypertensive cardio-renal vascular disease — 10 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C): senility

2602

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Diabetes Mellitus — 1-2 yrs; Chronic Prostatic Hypertrophy — 3 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 19 44, to May 19, 19 56, that I last saw the deceased alive on May 16, 19 56, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE AND M.D.: Lester W. Harris — ADDRESS (Street, city, town, state): 10111 Colesville Rd Silver Spring Md. — DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	5/22/56	CONGRESSIONAL CEMETERY	WASHINGTON, D.C.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
5/24/56	Frances Potter	Warner E. Pumphrey	SILVER SPRING, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05277

5295

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Woodfield
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D. Gaithersburg

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Woodfield
d. STREET ADDRESS: R.F.D. Gaithersburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Viola — Middle: Virginia — Last: Hamilton

4. DATE OF DEATH: Month: May — Day: 12 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 13, 1874

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joshua Stup

14. MOTHER'S MAIDEN NAME: L. Virginia Zimmerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Earl Hamilton, Gaithersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
422.1

DUE TO (b): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 15, 1951, to May 12, 1956, that I last saw the deceased alive on May 10, 1956, and that death occurred at 9:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Kerr M.D. — ADDRESS (Street, city or town, state): Damascus, Md. — DATE SIGNED: 5/14/56

PHYSICIAN'S NAME (Type): James P. Kerr M.D. — Damascus, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 15, 1956

22c. NAME OF CEMETERY OR CREMATORY: Wesley Grove

22d. LOCATION (City, town, or county) (State): Woodfield, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth — ADDRESS: Damascus, Md.

24a. REC'D BY REGISTRAR DATE: May 14/56

24b. REGISTRAR'S SIGNATURE: Della V. Burdette

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death: Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05278

5296

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 18 Mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Alta Vista Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 3712 Bradley La
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Elizabeth Middle Agnes Last HAND
4. DATE OF DEATH: Month May Day 31 Year 1956

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 12 1882
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months 6 Days XXX
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Mulled
14. MOTHER'S MAIDEN NAME: Agnes Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: No
17. INFORMANT: John Hand 3618 Raymond st. Address Ch. Gr. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Left Ventricular Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): acute Pulmonary Edema
DUE TO (c): Generalized Arteriosclerotic Hypertensive Heart disease — years

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1954, to May 31, 1956, that I last saw the deceased alive on 5-31-56 19, and that death occurred at 12.05 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: P. P. Andrews M.D. ADDRESS (Street, city or town, state): 4201 Fessenden St. N.W. Washington D.C. DATE SIGNED: 5-31-56
PHYSICIAN'S NAME (Type): P. P. ANDREWS M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
22b. DATE THEREOF: 6-6-56
22c. NAME OF CEMETERY OR CREMATORY: The Pines
22d. LOCATION (City, town, or county): Opportunity (State): Wash

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda Md.
24a. REC'D BY REGISTRAR DATE: 5-31-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5297 — 05272 — Reg. Dist. No. 14

1. PLACE OF DEATH
a. COUNTY: Montg — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 11 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2212 Washington Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2212 Washington Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Caroline — Middle: Elizabeth — Last: Harkins

4. DATE OF DEATH: Month: May — Day: 24 — Year: 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-3-1918
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John P Aderhold
14. MOTHER'S MAIDEN NAME: Grace Salbada

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 206-10-7512
17. INFORMANT: Richard Harkins (Husband) — Address: Same as Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-24-56

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL
22b. DATE THEREOF: 5/24/56
22c. NAME OF CEMETERY OR CREMATORY: Bradford Co. Mem. Park Cemetery
22d. LOCATION (City, town, or county) (State): Luther Mills, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Trump Assoc
ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: 5/27/56
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DE... MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... necessary, please exe... cate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer... or. Page 4 should be forwarded ... the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05280

CERTIFICATE OF DEATH

5298

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Montgomery Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4 yr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1923 - East West Hgwy

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1923 - East West Hgwy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: T — Last: HEFFNER

4. DATE OF DEATH: Month: MAY — Day: 6 — Year: 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN, 30

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Hampshire

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael O'Malley

14. MOTHER'S MAIDEN NAME: Katherine Teresa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs. Edward P. Heffner 1923 - East West Hgwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c): Arteriosclerosis — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No injury

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 19 56, to May 6, 1956, that I last saw the deceased alive on May 6, 1956, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Helen J. de S. Coutinho, M.D. — ADDRESS (Street, city or town, state): 1890 - Ontario Pl. N.W. Wash. 9, D.C. — DATE SIGNED

PHYSICIAN'S NAME (Type): HELEN J. de S. COUTINHO — 1890 ONTARIO PL. N.W. - WASH. 9, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-9-56

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

22d. LOCATION (City, town, or county) (State): Wash - D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon — ADDRESS: 3831 - Ga. Ave NW

24a. REC'D BY REGISTRAR DATE: 5/7/56

24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5299

CERTIFICATE OF DEATH

Reg. Dist. No. 05284 2-16

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 10 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Walton

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda, Md.

d. STREET ADDRESS: none

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Bette Middle Annette Last Hensley

4. DATE OF DEATH: Month May Day 10, Year 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 1, 1949

9. AGE (In years last birthday): 6 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Hensley

14. MOTHER'S MAIDEN NAME: Bette Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: none

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): intra cranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

2040

DUE TO (b): bronchopneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): acute lymphocytic leukemia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 30, 19 56, to May 10, 19 56, that I last saw the deceased alive on May 10, 19 56, and that death occurred at 1:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Mehran Goulian M.D.
ADDRESS (Street, city or town, state): The Clinical Center
DATE SIGNED: 5/10/56

PHYSICIAN'S NAME (Type): Mehran Goulian
Mehran Goulian M. D.
The National Institutes of Health
Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-13-56

22c. NAME OF CEMETERY OR CREMATORY: Eventide Cemetery

22d. LOCATION (City, town, or county) (State): Spencer W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 5-11-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5300

CERTIFICATE OF DEATH

05282 14
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 16 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1909 LANSDOWNE WAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: md — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 1909 LANSDOWNE WAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

56 M 00

3. NAME OF DECEASED (Type or print): First BERTHA — Middle KNOWLES — Last HESLET
4. DATE OF DEATH: Month MAY — Day 4 — Year 19 56
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH 14, 1872
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BENJAMIN LACEY KNOWLES
14. MOTHER'S MAIDEN NAME: RHODA ANN LONGSHORE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MARY R. HESLET — Address: 1909 LANSDOWNE WAY SILVER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Arteria-Sclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 2, 1956 to May 4, 1956, that I last saw the deceased alive on May 3, 1956, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Stuart Lyddane — M.D. — ADDRESS (Street, city or town, state): 3006 Cumberland, Md. — DATE SIGNED:
PHYSICIAN'S NAME (Type): E. STUART LYDDANE — Washington D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: May 12. 1956
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Fillmore Lee — ADDRESS: Lee's Sons Co 306-4th N.W.
24a. REC'D BY REGISTRAR DATE: 5/7/56
24b. REGISTRAR'S SIGNATURE: Frances Fuller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05283

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
5238
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
1617.2
d. STREET ADDRESS: 7204 13th ~~St~~ AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert ~~William~~ Middle: Harold Last: Hoch

4. DATE OF DEATH: Month: May Day: 26 Year: 1956

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/18/51

9. AGE (In years last birthday): 4 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? Amer

13. FATHER'S NAME: Charles Hoch

14. MOTHER'S MAIDEN NAME: Georgia Mae Hoch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.

17. INFORMANT: mother
Address: Takoma Park Police Dept.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thoracic hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
919.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bullet wound through chest — 5 min.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
shot self while playing with pistol

20c. TIME OF INJURY Hour: 7:45 (a. m. / p. m.) Month, Day, Year: 5/26 1956

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Takoma Park P. G. Co. Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5/26/56

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 29, 1956
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Prince Geo Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur Walters
ADDRESS: 254 Carroll St. N.E.
24a. REC'D BY REGISTRAR DATE: 5/28/56
24b. REGISTRAR'S SIGNATURE: J Hilton Deeds

TO DISPOSITION MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5301

CERTIFICATE OF DEATH

05284

Reg. Dist. No. 2-17

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Eliza Middle E. Last Hopkins

4. DATE OF DEATH Month May Day 26 Year 1956

5. SEX Female

6. COLOR OR RACE Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH August 26 1862

9. AGE (In years last birthday) 93 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Prestley Awkward

14. MOTHER'S MAIDEN NAME Lavenia Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Robert Hopkins Address Sandy Spring, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH 2 days

DUE TO (b) Cardiac incompetency — 3 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X

DUE TO (c) Hypertensive Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Parkinsonian Syndrome

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 10, 1950, to May 6, 1956, that I last saw the deceased alive on May 6, 1956, and that death occurred at 10 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Webster Sewell M.D. ADDRESS (Street, city or town, state) Norbeck Rt 1 Silver Spg. DATE SIGNED 5-8-56

PHYSICIAN'S NAME (Type) WEBSTER SEWELL

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 5/9/56

22c. NAME OF CEMETERY OR CREMATORY Ash Memorial

22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Saunders ADDRESS Rockville, Md.

24a. REC'D BY REGISTRAR DATE 5-6-56

24b. REGISTRAR'S SIGNATURE Gertrude B Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05285 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 26 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7717 Carroll Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Calvin — Middle Taylor — Last Hudson
4. DATE OF DEATH: Month 5 — Day 3 — Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 17 1900
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md. North Beach, Worcester County
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: John A. J. Hudson
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Rodney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 222-03-4644
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock - Subdural Hemorrhage & — INTERVAL BETWEEN ONSET AND DEATH: 25 hrs

DUE TO (b): Cerebral contusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Fracture of skull (left parietal)

816X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): He driving car which ran from stop sign & struck by other car
20c. TIME OF INJURY: Hour 10 o. m. p. m. — Month, Day, Year: 5-2-1952
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street
20f. (City or town) Takoma Park (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-4-56

EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/7/56
22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN
22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage
ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: MAY 8 1956
24b. REGISTRAR'S SIGNATURE: J. Nelson Todd

TO DE... MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... necessary, please exe... cute ... cate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funer... forwarde... the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file... TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05286

5302

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN 1b: 34 YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 120 Quincy Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): CHEVY CHASE
d. STREET ADDRESS: 120 QUINCY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle NONE — Last HUGHES

4. DATE OF DEATH: Month MAY — Day 27 — Year 1956

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT. 24, 1881

9. AGE (In years last birthday) 74 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BRICKLAYER-CONTRACTOR

10b. KIND OF BUSINESS OR INDUSTRY: BRICK-CONTRACTOR

11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS HUGHES

14. MOTHER'S MAIDEN NAME: HARRIET MANDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: SON-DONALD HUGHES — Address: 120 QUINCY ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS
420.1
DUE TO
(b): CORONARY ARTERY DISEASE — UNDETERMINED.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 7, 1956, to 27 May, 1956, that I last saw the deceased alive on 27 May, 1956, and that death occurred at 11 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph L Conroy M.D. — ADDRESS (Street, city or town, state): 9600 OLD GEORGETOWN ROAD — DATE SIGNED

PHYSICIAN'S NAME (Type): BETHESDA 14 MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 5/31/56

22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

22d. LOCATION (City, town, or county) (State): Montgomery Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., 2901 14th St. N.W. — ADDRESS: Wash, D.C.

24a. REC'D BY REGISTRAR DATE 5-30-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5240

CERTIFICATE OF DEATH

05287 4/23
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park Md.
c. LENGTH OF STAY IN 1b 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena 02X-2
d. STREET ADDRESS Rock Hill Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Elma Middle Elsie Last Hyland
4. DATE OF DEATH Month 5- Day 28- Year 19 56

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-19-1902
9. AGE (In years last birthday) 54 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months, Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Parks
14. MOTHER'S MAIDEN NAME Myrtus Landon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Washington Sanitarium + Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Tuberculous bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: few days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic ulcerative tuberculosis, lung — several yrs.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 May, 1956, to 28 May, 1956, that I last saw the deceased alive on 28 May, 1956, and that death occurred at 12 20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Chas. H. Wolohon M.D.
ADDRESS (Street, city or town, state) 6710 Inglewood Dr. Wash 39 D.C.
DATE SIGNED 5/28/56
PHYSICIAN'S NAME (Type) Chas H Wolohon

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May 31/56
22c. NAME OF CEMETERY OR CREMATORY Glen Haven
22d. LOCATION (City, town, or county) (State) Glen Burnie Md

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS Langston Funeral Home Glen Burnie Md.
24a. REC'D BY REGISTRAR DATE JUN 6 1956
24b. REGISTRAR'S SIGNATURE J. Halsey Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5303

CERTIFICATE OF DEATH

Reg. Dist. No. 05288 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — STATE: MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
STATE: District of Columbia — COUNTY: 47 x 3

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda, Maryland

c. LENGTH OF STAY IN 1b: 23 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda, Md.

d. STREET ADDRESS: 1341 A Street, N. E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Marie — Last: Johnson

4. DATE OF DEATH: Month: May — Day: 4, — Year: 1956

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ Sep DIVORCED ☐

8. DATE OF BIRTH: October 26, 1900

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Household duties

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Jackson

14. MOTHER'S MAIDEN NAME: Catherine Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: not available

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Paroxysmal Atrial Flutter — INTERVAL BETWEEN ONSET AND DEATH

141 x

DUE TO (b): Metastatic Carcinoma Lung

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Carcinoma of Tongue

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 11, 1956 to May 4, 1956 that I last saw the deceased alive on May 4, 1956, and that death occurred at 1 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ted Clemens Jr M.D.

ADDRESS (Street, city or town, state): The Clinical Center, The National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED

PHYSICIAN'S NAME (Type): TED CLEMENS, JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-8-56

22c. NAME OF CEMETERY OR CREMATORY: St. Joseph's Cemetery

22d. LOCATION (City, town, or county) (State): Charles County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Montgomery Bros. — ADDRESS: 913-7th St. NW

24a. REC'D BY REGISTRAR DATE: 6-16-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05289

5304

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norbeck
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bradford Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Carrie ~~Johnson~~ — Middle: Dorsey — Last: Johnson

4. DATE OF DEATH: Month: May — Day: 18 — Year: 1956

5. SEX: femal

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 12,1873

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Dorsey

14. MOTHER'S MAIDEN NAME: Rachel Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert A. Johnson — Address: Sandy Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Hepatic and Colon — INTERVAL BETWEEN ONSET AND DEATH: 1953

199.8

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive Cardiorenal D. Arthritis Herpes Zoster

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 26, 1936 to May 18, 1956, that I last saw the deceased alive on May 17, 1956, and that death occurred at 7:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Webster Sewell M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED:

PHYSICIAN'S NAME (Type): Webster Sewell, M.D. — Norbeck Rt.1 Silver Spring

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/21/56

22c. NAME OF CEMETERY OR CREMATORY: Sandy Spring,

22d. LOCATION (City, town, or county) (State): Sandy Springs, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: 5-23-56

24b. REGISTRAR'S SIGNATURE: Gertrude B Lawson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

MAY 23 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5305 — 05290 — Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Suburban Hosp

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: md — b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring R-2
d. STREET ADDRESS: Stewart Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: Amanda — Last: Johnson
4. DATE OF DEATH: Month: May — Day: 2 — Year: 1956

5. SEX: Female — 6. COLOR OR RACE: col — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 9-30-1894 — 9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): md — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elias MaThews — 14. MOTHER'S MAIDEN NAME: Lucinda Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Address: Catherine Sedywick (daughter) same as Item 5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3½ hr.
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I taak charge of the remains described abave, held an Autapsy ☐, Inspectian ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-2-56

EXAMINER'S NAME (Type): Frank J Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 5/5/56 — 22c. NAME OF CEMETERY OR CREMATORY: Good Hope — 22d. LOCATION (City, town, or county) (State): Colesville, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville Md — 24a. REC'D BY REGISTRAR DATE 5-7-56 — 24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DE... MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any c... necessary, please exe... cute, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer... Page 4 should be forwarded ... the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05291

5306

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — STATE: MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
STATE: District of Columbia — COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 26 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 1200 "O" Street, N. W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomasena — Middle: (none) — Last: Johnson

4. DATE OF DEATH: Month: May — Day: 20, — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: September 23,1905

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Household duties

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samson Peoples

14. MOTHER'S MAIDEN NAME: Anneta Persons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-40-2542

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of breast c metastasis to axillary lymph nodes, mediastinal
DUE TO (b): lymph nodes, abdominal lymph nodes
DUE TO (c): and brain

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170X

INTERVAL BETWEEN ONSET AND DEATH: months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 24, 1956, to May 20, 1956, that I last saw the deceased alive on May 20, 1956, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. M. Headley M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED

PHYSICIAN'S NAME (Type): William M. Headley, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5-21-56

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Otis F. Allen — ADDRESS: 1200 Fla. Ave. N.W. W.D.C.

24a. REC'D BY REGISTRAR DATE: 5-22-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5307

05292

Reg. Dist. No. 3-17

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 1 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SHARON CRONIC HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 7400 Bradley Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elenor; Middle: ; Last: Karsten

4. DATE OF DEATH: Month: May; Day: 7; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 3, 1891

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Indianapolis Ind.

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Charles E. Cox

14. MOTHER'S MAIDEN NAME: Emma Mason Cooley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ## (If yes, give war or dates of service): ####

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Mrs Karl Karsten

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs.
DUE TO
4222
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Rheumatoid arthritis — 17 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 9, 1935, to May 7, 1956, that I last saw the deceased alive on April 28, 1956, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Katharine A. Chapman M.D. — ADDRESS (Street, city or town, state): 3934 Baltimore St. — DATE SIGNED: May 7, 1956

PHYSICIAN'S NAME (Type): KATHARINE A CHAPMAN — Kensington, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: May. 7, 1956

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

22d. LOCATION (City, town, or county) (State): Prince Geog. Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Roy W Barber, Laytonsville, Md.

24a. REC'D BY REGISTRAR DATE: 5-9-56

24b. REGISTRAR'S SIGNATURE: Gertrude B Fowler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5293

Item 9, Film G198 6-14-56 et

5308

CERTIFICATE OF DEATH

Reg. Dist. No. 2-17

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND Co. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney LENGTH OF STAY (in this place) 4 yrs HOSPITAL OR INSTITUTION OR STREET ADDRESS None

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Mont. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Ozella (Last) Kengla

4. DATE OF DEATH: (Month) May (Day) 28 (Year) 1956

5. SEX: Female 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow 8. DATE OF BIRTH: Sept 26 1875 9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home 10B. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Washington D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Schneider 14. MOTHER'S MAIDEN NAME: Mary Ozella Ellis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no 16. SOCIAL SECURITY NO. no 17. INFORMANT & ADDRESS: Mrs Lewis R. Kengla

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X

IMMEDIATE CAUSE (A) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH 1 yr

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1955, to May, 1956, that I last saw the deceased alive on May 27, 1956, and that death occurred at 1:45 PM, from the causes and on the date stated above.

SIGNATURE A.D. Bricant M.D. ADDRESS Sandy Spring Md DATE SIGNED 5/28/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF May 31/56 NAME OF CEMETERY OR CREMATORY Parklawn LOCATION (City, town, or county) Rockville (State) Md

DATE REC'D BY LOCAL REGISTRAR 5-28-56 REGISTRAR'S SIGNATURE Gertrude B Fowler 24. FUNERAL DIRECTOR Adams Funeral Home ADDRESS 4724 E. Wis Ave. N.W.

VS. A15 — 10 - 55

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5399

CERTIFICATE OF DEATH

05294

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 134 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4306 Tuckerman Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16-15-2

3. NAME OF DECEASED (Type or print): First: Malcolm; Middle: Henderson; Last: Kerr

4. DATE OF DEATH: Month: May; Day: 16; Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 7, 1901

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Professor

10b. KIND OF BUSINESS OR INDUSTRY: University

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Charles M. Kerr

14. MOTHER'S MAIDEN NAME: Annie Dodge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: 550-09-2173

17. INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda, 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal Insufficiency and Uremia — INTERVAL BETWEEN ONSET AND DEATH
289.1
DUE TO (b): Primary Generalized Amyloidosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour o. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 3, 1956, to May 16, 1956, that I last saw the deceased alive on May 16, 1956, and that death occurred at 1:15P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John T. Binion M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: May 16, 1956

PHYSICIAN'S NAME (Type): John T. Binion, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 18, 1956
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Colmar Manor Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: F. Gasch's Sons Hyattsville, Maryland

24a. REC'D BY REGISTRAR DATE: MAY 21 1956

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5310 **CERTIFICATE OF DEATH**

05295
Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DC. — b. COUNTY: 47-3 ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4726 Reno Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Sixtus — Last: Kettler
4. DATE OF DEATH: Month: May — Day: 22 — Year: 19 56

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 7 1890
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Examiner
10b. KIND OF BUSINESS OR INDUSTRY: Interstat Commerce Comm.
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Kettler
14. MOTHER'S MAIDEN NAME: Harriet Beier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Thelma Kettler — Address: 4726 Reno Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction	1 Mo.
DUE TO (b)	Coronary Artery Thrombosis	1 Mo
DUE TO (c)	Coronary Artery Sclerosis	

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 23, 1956 to May 22, 1956 that I last saw the deceased alive on May 21, 1956, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Harell M.D. — ADDRESS (Street, city or town, state): 5516 Nebraska Ave. N.W. Wash. D.C. — DATE SIGNED: 5/22/56

PHYSICIAN'S NAME (Type): Robert A. Harell — 5516 Nebraska Ave. N.W. Wash. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 5/24/56
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co., 2901 14th St. N.W. — ADDRESS: Wash, D.C.
24a. REC'D BY REGISTRAR DATE: 5-24-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5311

05296

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 17½ hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Dist. of Col. — b. COUNTY: 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2745 - 29th St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle Michael — Last Kirby

4. DATE OF DEATH: Month May — Day 15 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 3, 1876

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months 6 — Days 12
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate

10b. KIND OF BUSINESS OR INDUSTRY: Real Estate

11. BIRTHPLACE (State or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Kirby

14. MOTHER'S MAIDEN NAME: Margaret Flemming

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 006-10-4888

17. INFORMANT: John J. Kirby, 609 Knollwood Dr. — Address: Falls Church, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardio-Vascular-Renal Disease — 3 yrs
DUE TO
(c)

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 5, 1956, to May 15, 1956, that I last saw the deceased alive on May 15, 1956, and that death occurred at 2:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sidney C Cousins M.D. — ADDRESS (Street, city or town, state): 3921 Longfellow St Hyattsville Md — DATE SIGNED: May 15 1956

PHYSICIAN'S NAME (Type): SIDNEY C COUSINS — Wash. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-18-56
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 5-16-56

24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5312 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05297
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12604 Holdridge Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Roger Last Knight
4. DATE OF DEATH: Month May Day 17 Year 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-14-1923
9. AGE (In years last birthday): 33 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter and Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Contracting Co.
11. BIRTHPLACE (State or foreign country): Howard Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Roger Knight
14. MOTHER'S MAIDEN NAME: Nettie Elizabeth Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW #2
16. SOCIAL SECURITY NO.: 214-12-7996
17. INFORMANT: Sister Bessie Mae Howse Address: Spencerville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.
910.5
DUE TO (b): Abdominal Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Crushed pelvis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Crushed while attempting to load bulldozer on a tractor
20c. TIME OF INJURY: Hour 11:45 a. m. p. m. Month, Day, Year 5-16 1956
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street
20f. (City or town) Bethesda (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Boschert M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BOSCHERT
DATE SIGNED: 5-17-56

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/21/56
22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: MAY 21 1956
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... necessary, please exe... cute ... date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral ... forwarded ... the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5313 **CERTIFICATE OF DEATH** 05298

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 6 MO, 10 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: SHARON CHRONIC HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 9916 ROGART ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SOPHIA — Middle LOUISE — Last KOHR

4. DATE OF DEATH: Month MAY — Day 17 — Year 1956

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 31, 1870

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOCIAL SERVICE WORKER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MANSFIELD, PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIEL DOTY

14. MOTHER'S MAIDEN NAME: ESTER HOLLY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 579-12-5069D

17. INFORMANT — Address: MR. H. G. BRUNK, 9916 Rogart Road Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia (Recurrent) — INTERVAL BETWEEN ONSET AND DEATH: 5 weeks
493X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1955 to May 17, 1956, that I last saw the deceased alive on May 13, 1956, and that death occurred at 11:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John N. Andrews M.D. — ADDRESS (Street, city or town, state): 9601 Colesville Rd Silver Spring Md — DATE SIGNED: May 17-56

PHYSICIAN'S NAME (Type): John N. Andrews M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/21/56

22c. NAME OF CEMETERY OR CREMATORY: NATIONAL MEM. PARK CEMETERY

22d. LOCATION (City, town, or county) (State): FALLS CHURCH, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: MAY 21 1956

24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65299

5314

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 15 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Monty Co. Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: 4 X 3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 438 10th St. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roger — Middle: Edgar — Last: Lancaster

4. DATE OF DEATH: Month: May — Day: 20 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-27-1954

9. AGE (In years last birthday): 2 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Wash. DC.

12. CITIZEN OF WHAT COUNTRY? USE.

13. FATHER'S NAME: Roger Lancaster

14. MOTHER'S MAIDEN NAME: Pauline Prather

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Pauline Prather (mother) Same as Item 7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage uterus & brain (Ht failure) — INTERVAL BETWEEN ONSET AND DEATH: 10 mo

902.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Fracture of skull 7-6-55

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell from porch at home to concrete basement

20c. TIME OF INJURY: Hour: 2 p.m. — Month, Day, Year: 7-6 1955

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Washington DC

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 5-20-56

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: May 23 56

22c. NAME OF CEMETERY OR CREMATORY: Brookgrove md

22d. LOCATION (City, town, or county) (State): Laytonsville md

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W Barber

ADDRESS: Laytonsville md

24a. REC'D BY REGISTRAR DATE: 5-28-56

24b. REGISTRAR'S SIGNATURE: Gertrude B Lawler

TO DE... MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... necessary, please exe... cute ... state, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer... Page 4 should be forwarded ... the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5315

CERTIFICATE OF DEATH

65300

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 40 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 10516 Wheatley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harvey — Middle: Holt — Last: Langley, Jr.

4. DATE OF DEATH: Month: May — Day: 15, — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 31, 1946

9. AGE (In years last birthday): 9 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School boy

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Harvey Langley

14. MOTHER'S MAIDEN NAME: Alta Riley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastro-intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Acute lymphocytic leukemia
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
DUE TO
(c):

204.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): O.B. coli + Klebsella septicemia @ Bronchopneumonia RLL, RML, LLL

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 5, 19 56, to May 15, 19 56, that I last saw the deceased alive on May 15, 19 56, and that death occurred at 11:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur George Ship M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: May 15, 1956

PHYSICIAN'S NAME (Type): Arthur G. Ship, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
22b. DATE THEREOF: 5-17-56
22c. NAME OF CEMETERY OR CREMATORY: Cedar Grove Cem.
22d. LOCATION (City, town, or county) (State): Wilson County, No.Car.

23. FUNERAL DIRECTOR'S SIGNATURE: T.W.Cobb T. W. Cobb
ADDRESS: Elm City, No.Car.
24a. REC'D BY REGISTRAR DATE: 5-16-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

053011

5316

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): South Charleston
d. STREET ADDRESS: 826 Jefferson Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Gerald — Middle: Everett — Last: Lanier

4. DATE OF DEATH: Month: May — Day: 9, — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 3, 1946

9. AGE (In years last birthday): 9 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Donald Lanier

14. MOTHER'S MAIDEN NAME: Virginia Stover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Possible intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Acute lymphocytic leukemia
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2040

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 8, 1956, to May 9, 1956, that I last saw the deceased alive on May 9, 1956, and that death occurred at 9:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Schick M.D.

ADDRESS (Street, city or town, state): The Clinical Center, The National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 5/9/56

PHYSICIAN'S NAME (Type): Martin Schick, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit

22b. DATE THEREOF: 5-12-56

22c. NAME OF CEMETERY OR CREMATORY: Graceland Mem. Park.

22d. LOCATION (City, town, or county) (State): Kanawha Co., West Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: A. D. Egnan
Degnan Funeral Home
ADDRESS: South Charleston, West Virginia.

24a. REC'D BY REGISTRAR DATE: 5-11-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5317 — 05302 — Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3611 Sheppard st

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: md — b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3611 Sheppard st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Riggs — Last: Ledig

4. DATE OF DEATH: Month: May — Day: 1 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 20, 1882

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months: 3 — Days: 11
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Ill.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ? Riggs

14. MOTHER'S MAIDEN NAME: ? Stacey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 578-07-8179

17. INFORMANT Address: Mrs J. Reynolds Smith, Sr.-Item# 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-1-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-4-56
22c. NAME OF CEMETERY OR CREMATORY: George Washington
22d. LOCATION (City, town, or county) (State): Prince George Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 5/3/56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DULY QUALIFIED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only external examination necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5318

05303 2 16
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 11 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CLINICAL CENTER, NIH

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE (29) 03X-2
d. STREET ADDRESS: 5419 WHITLOCK ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ALMA Middle ELIZABETH Last LEE

4. DATE OF DEATH: Month MAY Day 5 Year 1956

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT 2 1920

9. AGE (In years last birthday): 35 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: HARRY B. BLANCHARD

14. MOTHER'S MAIDEN NAME: ALMA SWANN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-09-8514

17. INFORMANT: THE MEDICAL RECORD Address: THE CLINICAL CENTER, BETHESDA 14 MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HODGKINS DISEASE — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
201X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL 24, 1956, to MAY 5, 1956, that I last saw the deceased alive on MAY 5, 1956, and that death occurred at 9:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Schick M.D.
ADDRESS (Street, city or town, state): THE CLINICAL CENTER THE NATIONAL INSTITUTES OF HEALTH BETHESDA 14 MARYLAND
DATE SIGNED: 5/6/56

PHYSICIAN'S NAME (Type): MARTIN SCHICK M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAY 9, 1956
22c. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
22d. LOCATION (City, town, or county) (State): BALTO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Harry H. Witzke
ADDRESS: 4101 EDMONDSON AVE
24a. REC'D BY REGISTRAR DATE: MAY 8
24b. REGISTRAR'S SIGNATURE: Mrs. Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5319 **CERTIFICATE OF DEATH** 05304

Reg. Dist. No. 216

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Montgomery — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

LENGTH OF STAY (In this place): 25 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: D.C. — COUNTY:

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington — 47X-3

STREET ADDRESS (If rural give location): 6135 30th St. N.W.

3. NAME OF DECEASED (Type or Print): (First) Katherine (Middle) Mattern (Last) Lewis

4. DATE OF DEATH: (Month) May (Day) 9 (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	Feb. 9, 1876	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fitter	Dept. Store	Washington D.C.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter Mattern	Christine Dill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
		Christine Mattern - Sister 6135 - 30th St, N.W. Wash. D.C.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 25 days

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Cerebral Arteriosclerosis — 5 yrs.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED White at work ☐ Not white at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from June 19 51, to May 9, 19 56, that I last saw the deceased alive on May 8, 19 56, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

SIGNATURE: Robert Morrell M.D. — ADDRESS (Street, city, town, state): 5516 Nebraska Ave D.C. — DATE SIGNED: 5-9-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/11/56	Rock Creek Cemetery	Washington, D. C.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
5-10-56	Bessie M. Thompson	L. H. Hines Co.	2901 14th St NW Wash. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5320

CERTIFICATE OF DEATH

Reg. Dist. No. 05305

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL BETHESDA
c. LENGTH OF STAY IN 1b: 18 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USNH, NNMC, BETHESDA, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: ARLINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARLINGTON
d. STREET ADDRESS: 413 N. GEORGE MASON DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle CLIFTON — Last LOVENBERG

4. DATE OF DEATH: MAY 15 1956

5. SEX: MALE

6. COLOR OR RACE: CA

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/26/26

9. AGE (In years last birthday): 29 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RESEARCH CHEMIST

10b. KIND OF BUSINESS OR INDUSTRY: BUORD USN

11. BIRTHPLACE (State or foreign country): R.I.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CLIFTON LOVENBERG

14. MOTHER'S MAIDEN NAME: FRANCES DARLING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW-II

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: ELNORA LOVENBERG — Address: 413 N. GEORGE MASON DR. ARLINGTON.VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pneumonia, lobular	2 days
DUE TO (b)	Leukemia, granulocytic, Acute	2½ wks
DUE TO (c)	Leukemia, granulocytic, chronic	5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 28 April 1956 to 15 May 1956 that I last saw the deceased alive on 15 May 1956, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. B. Ingram M.D. ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. DATE SIGNED: 5-16-56

PHYSICIAN'S NAME (Type): William B. Ingram, CDR, MC, USN. U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 21 May 1956

22c. NAME OF CEMETERY OR CREMATORY: Swan Point Cemetery

22d. LOCATION (City, town, or county) (State): Providence, Rhode Island

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey — ADDRESS: Bethesda, Md. R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave.,

24a. REC'D BY REGISTRAR DATE: 4-16-56

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05306

Reg. Dist. No. 216

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is unknown, please execute, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Dist. of Columbia — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chevy Chase Club	d. STREET ADDRESS: 2540 Mass. Ave. N.W. Apt. 308 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: THOMAS	Middle: HIXON	Last: LOWE	4. DATE OF DEATH	Month: May	Day: 19	Year: 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 7-16-1879	9. AGE (In years last birthday): 76 yrs.	IF UNDER 1 YEAR: Months: 10	Days: 3	IF UNDER 24 HRS.: Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Army Ret.	10b. KIND OF BUSINESS OR INDUSTRY: Govt.	11. BIRTHPLACE (State or foreign country): Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William M. Lowe		14. MOTHER'S MAIDEN NAME: Barbara C. Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I & II	16. SOCIAL SECURITY NO.: No	17. INFORMANT: Sarah I. Lowe, Wife	Address: Above Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-19-56

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	5-22-1956	Arlington Nat. Cem.	Arlington	Va.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey	Bethesda Md.	5-21-56	Bernie M. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05307

5241

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 804 Maplewood Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 804 Maplewood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MAY — Middle: — Last: LUCAS

4. DATE OF DEATH: Month: May — Day: 10 — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 7, 1873.

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Long Island, New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rueben Arthur

14. MOTHER'S MAIDEN NAME: Charlotte PAINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. O. E. Mathiason, Calonia, New Jersey

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — 420.1 — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days
DUE TO: Coronary atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral arteriosclerosis with
DUE TO: residual right hemiplegia
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 19 56, to May 10, 19 56, that I last saw the deceased alive on May 10, 19 56, and that death occurred at 5:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas H. Wolohon M.D.
ADDRESS (Street, city or town, state): 500 Underwood St. N. W. Washington, D. C.
DATE SIGNED: 5/10/56

PHYSICIAN'S NAME (Type): Charles H. Wolohon

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: May 12, 1956.
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Pr. Geo. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Theodosius L. Waldorf
ADDRESS: Takoma Park, DC. 254 Carroll St. N. W.,
24a. REC'D BY REGISTRAR DATE: 5/11/56.
24b. REGISTRAR'S SIGNATURE: J. Hickson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5242

CERTIFICATE OF DEATH

05308

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 63 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. + Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: P.O. Box 7812 Ben Franklin Station
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Louis; Last: Luedtke

4. DATE OF DEATH: Month: May; Day: 28; Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 2, 1883

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Foreign Service man

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Emily P. Euergen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
603X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 28, 19 55, to May 28, 19 56, that I last saw the deceased alive on May 26, 19 56, and that death occurred at 9:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J W Whitlock M.D.
ADDRESS (Street, city or town, state): Wash. San + Hospit. Takoma Park Md
DATE SIGNED
PHYSICIAN'S NAME (Type): J. W. WHITLOCK

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 5/28/56
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Lanham Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 1400 Chapin St NW
24a. REC'D BY REGISTRAR DATE: 5/29/56
24b. REGISTRAR'S SIGNATURE: Hilton Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05309

5322

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 8607 Lancaster Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George — Middle: Wilson — Last: Lyon

4. DATE OF DEATH: Month: May — Day: 5 — Year: 1956

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-14-84

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Govt.

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Oscar Lyon

14. MOTHER'S MAIDEN NAME: M. Edna Hardenburg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Helene P. Lyon-Item# 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 wk.
DUE TO (b): Carcinoma - prostate or rectum — 3 mo / 10 yr
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1547

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1936, to May 5, 1956, that I last saw the deceased alive on May 5, 1956, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wyrth Post Baker M.D.
ADDRESS (Street, city or town, state): 1635 HARVARD St. Wash. DC
DATE SIGNED:
PHYSICIAN'S NAME (Type): WYRTH POST BAKER

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 5/7/56
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 5-8-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5323 CERTIFICATE OF DEATH

05310
Reg. Dist. No. 226

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: No.1.Lawrence Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH — Middle ALMA — Last MCGUINNESS

4. DATE OF DEATH: Month May — Day 30 — Year 19 56

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Oct.11, ?
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reg.Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 018-12-6061
17. INFORMANT — Address: Ruth M. Aubrey, Daughter-Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease — years
DUE TO
(c): Hypertensive encephalopathy — " "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral vascular accident
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 55 to 5/30, 19 56 that I last saw the deceased alive on 5/30, 19 56, and that death occurred at 9:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles M. Weber M.D. — ADDRESS (Street, city or town, state): 1260 OAKLAND DR Rockville Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Charles M. Weber

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-2-56
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cem.
22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 5-31-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05311

5324

CERTIFICATE OF DEATH

214

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 136 SOUTHWOOD AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 136 SOUTHWOOD AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle FLETCHER — Last MERRICK

4. DATE OF DEATH: Month MAY — Day 22 — Year 1956

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 11, 1889

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONDUCTOR (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: PENNA. RAILROAD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BENJAMIN F. MERRICK

14. MOTHER'S MAIDEN NAME: MARGARET R. FLETCHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 717-07-5882

17. INFORMANT: Mrs. Mary E. Merrick, 136 Wouthwood Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — 4 years

DUE TO (c): with auricular Fibrillation — 1½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 1954 to May 22 1956 that I last saw the deceased alive on April 26 1956, and that death occurred at 7:10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Russell B. Arnold M.D. — ADDRESS (Street, city or town, state): 8801 Colesville Road, Silver Spring, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): RUSSELL B. ARNOLD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/25/56

22c. NAME OF CEMETERY OR CREMATORY: EAST NEW MARKET CEMETERY

22d. LOCATION (City, town or county) (State): EAST NEW MARKET, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner C. Pumphrey — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: 5/29/56

24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5325

CERTIFICATE OF DEATH

05312

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 2601 Ross Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Webster — Last: Mifflefon
4. DATE OF DEATH: Month: May — Day: 12 — Year: 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 24 1885
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel Webster Mifflefon
14. MOTHER'S MAIDEN NAME: Rosalee Rawlett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Alma Groves - Sister — Address: 2601 Ross Rd Chevy Chase Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bronchopneumonia, Terminal	2 days
DUE TO (b)	Carcinomatosis, Generalized	4 months
DUE TO (c)	Carcinoma, Papillary, Bladder	1 year

181X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis Generalized

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 24, 1955, to May 12, 1956, that I last saw the deceased alive on May 11, 1956, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert G. Angle M.D.
ADDRESS (Street, city or town, state): 5009 Del Ray Ave, Bethesda, Md.
DATE SIGNED: 5/12/56

PHYSICIAN'S NAME (Type): R obert G. Angle
5009 Del Ray Avenue, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/15/56
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Family Cemetery
22d. LOCATION (City, town, or county) (State): Owens, King Geo. Co., Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: James T. Pryor, Inc.
ADDRESS: 317 Pa. Ave. S. E. DC 3
24a. REC'D BY REGISTRAR DATE: MAY 14 1956
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05313

5326

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bunker Orchard
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gaithersburg R-3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Travilla
d. STREET ADDRESS Gaithersburg R-3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Alonzo Middle: Augustus Last: Mitchell
4. DATE OF DEATH Month: May Day: 27 Year: 1956
5. SEX: M
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-9-'05
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Mitchell
14. MOTHER'S MAIDEN NAME: Emma Imes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs Castile - Gaith. Md R-3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden
148X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Throat
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Frank J. Broschart M.D.
EXAMINER'S NAME (Type) FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5-27-56

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 5/31/56
22c. NAME OF CEMETERY OR CREMATORY Seneca
22d. LOCATION (City, town, or county) Seneca, Md (State)

23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Snowden — ADDRESS Rockville, Md
24a. REC'D BY REGISTRAR DATE 5-31-56
24b. REGISTRAR'S SIGNATURE Wm. H. L. Cooke

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... necessary, please execute ... wrote, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5327

CERTIFICATE OF DEATH

Reg. Dist. No. 2976 05314

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kenwood
c. LENGTH OF STAY IN 1b: 2 Mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6816 Millwood Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kenwood
d. STREET ADDRESS: 6816 Millwood Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA — Middle ELLA — Last MITCHELL

4. DATE OF DEATH: Month May — Day 30 — Year 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-27-1878

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months 5 — Days 3
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Mitchell

14. MOTHER'S MAIDEN NAME: Sarah Holleman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Dr. James S. Dryden — Address: Son-in-law — Kenwood Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARDIAC FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) GENERALIZED ARTERIO SCLEROSIS — 10 YEARS

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CEREBRAL VASCULAR ACCIDENT

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DECEMBER, 1955, to MAY 29, 1956, that I last saw the deceased alive on MAY 29, 1956, and that death occurred at 2:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frederick W. Coe M.D. — ADDRESS (Street, city or town, state): 1835 Eye St. N.W. Washington 6 D.C. — DATE SIGNED: May 30, 1956

PHYSICIAN'S NAME (Type): Frederick W. Coe — 1835 Eye St. N.W. Washington, DC May 30 1956

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-1-1956

22c. NAME OF CEMETERY OR CREMATORY: Aulander Cem.

22d. LOCATION (City, town, or county) (State): Aulander No. Car.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 6-30-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5328

Reg. Dist. No. 05315

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 2 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Monty Co. Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md — b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ashton
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hoyt — Middle: H. — Last: Morrison

4. DATE OF DEATH: Month: May — Day: 12 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-17-22

9. AGE (In years last birthday): 34 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: E M. Morrison

14. MOTHER'S MAIDEN NAME: Laura Hunstead

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW #2

16. SOCIAL SECURITY NO.: 412-24-8247

17. INFORMANT: Ruth Morrison (wife) — Address: Same as Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thoracic & Abdominal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Internal Injuries
DUE TO (c): a

825X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Comp fracture left leg

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was driver of car which went out of control

20c. TIME OF INJURY: Hour: 6:15 a.m. p.m. — Month, Day, Year: 5-12-1956

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) Ellicott (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Boschart M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-17-56

EXAMINER'S NAME (Type): FRANK J. BOSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Shipment

22b. DATE THEREOF: May 15, 1956

22c. NAME OF CEMETERY OR CREMATORY: Sugar Creek Cemetery

22d. LOCATION (City, town, or county) (State): Bradley County, Tennessee

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Warner E. Pumphrey Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: 5/16/56

24b. REGISTRAR'S SIGNATURE: Gertrude Lawler

TO DE[illegible] MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] necessary, please exe[illegible]cate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer[illegible]r. Page 4 should be forwarded [illegible] the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5329

05316 Reg. Dist. No. 211

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clagettsville
c. LENGTH OF STAY IN 1b: All Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clagettsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle A. — Last Moxley

4. DATE OF DEATH: Month May — Day 20 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ ## DIVORCED ☐

8. DATE OF BIRTH: Feb. I 1876

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Washington Moxley

14. MOTHER'S MAIDEN NAME: Sarah Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ## (If yes, give war or dates of service): #####

16. SOCIAL SECURITY NO.: #####

17. INFORMANT: James E. Moxley — Address: Mt. Airy Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Adams-Stokes Syndrome	2 mos.
DUE TO (b)	Arteriosclerotic Heart Disease	10 years or more
DUE TO (c)	Hypertension	20 years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized osteo-arthritis. Mild diabetes mellitus Old cerebro-vascular accident, Benign prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1955, to May 20 1956, that I last saw the deceased alive on May 20 1956, and that death occurred at 8:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gilcin F. Meadors Jr. M.D. — ADDRESS (Street, city or town, state): Boyer Clinic, Damascus, Md. — DATE SIGNED: 5/22/56

PHYSICIAN'S NAME (Type): Gilcin F. Meadors, Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 23

22c. NAME OF CEMETERY OR CREMATORY: Montgomery Chapel

22d. LOCATION (City, town, or county) (State): Clagettsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Royce Barber — ADDRESS: Laytonsville Md.

24a. REC'D BY REGISTRAR DATE: May 23, 1956

24b. REGISTRAR'S SIGNATURE: Della N. Burdette

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05317

5243

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Pk.
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash Sanitarium.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Pk.
d. STREET ADDRESS: 8502 Greenwood ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Eugene — Middle Duke — Last Mullin
4. DATE OF DEATH: Month 5 — Day 31 — Year 1956
5. SEX: male
6. COLOR OR RACE: Cau C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/28/03
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sec. Dept of ag.
10b. KIND OF BUSINESS OR INDUSTRY: Secretary
11. BIRTHPLACE (State or foreign country): New york.
12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME: Eugene W. Mullin
14. MOTHER'S MAIDEN NAME: Mary A Duke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: wife — Address: 8502 Greenwood ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchial Obstruction	1 week
DUE TO	162X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Primary Carcinoma of Bronchus	1 year.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 6, 1956, to May 31, 1956, that I last saw the deceased alive on May 31, 1956, and that death occurred at 1655 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilford D. Meyers M.D. — ADDRESS (Street, city or town, state): 8323 Hadden Dr — DATE SIGNED: 5-31-56

PHYSICIAN'S NAME (Type): WILFORD D. MEYERS.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 4-1956
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: L. Arthur Nellers — ADDRESS: 254 Conrad Ave

24a. REC'D BY REGISTRAR DATE: JUN 2 1956
24b. REGISTRAR'S SIGNATURE: J. Milton Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be verified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05318

5244 **CERTIFICATE OF DEATH**

Reg. Dist. No. 223

1. PLACE OF DEATH

COUNTY Montgomery — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park — LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 700 Hudson Ave. Eventide Rest Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE D.C. COUNTY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington

STREET ADDRESS (If rural give location) 4825 48th Street, N.W.

3. NAME OF DECEASED (Type or Print) (First) KATHRYN (Middle) (Last) MURRAY

4. DATE OF DEATH (Month) MAY (Day) 7 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		3-18-85	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seamstress	own business	Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Reynolds	Susan Roach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH few minutes

ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis — years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 20, 1946, to May 6, 1956, that I last saw the deceased alive on May 6, 1956, and that death occurred at 4:15 M, from the causes and on the date stated above.

SIGNATURE C.P. Ryland M.D. ADDRESS (Street, city, town, state) 4400-49 St NW, DATE SIGNED 5-7-56

23. BURIAL, CREMATION, ~~REMOVAL (SPECIFY)~~	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	5/9/56	Ft. Lincoln Cemetery	Pr. Geo. Co., Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
5/9/56	J. Walton Dodd, Registrar	The S.H. Hines Co. 2901 14th St. N.W. Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5245

CERTIFICATE OF DEATH

05319 223
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San+Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7105 Sycamore Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pearle — Middle: (none) — Last: Myers

4. DATE OF DEATH: Month: May — Day: 31 — Year: 1956

5. SEX: Fe

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 6-22-1898

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Geary Spicher

14. MOTHER'S MAIDEN NAME: Jennie Rolley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hosp Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Rhabdomyosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 18 mo
DUE TO
1956 1957
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-15-, 1956, to 5-31-, 1956, that I last saw the deceased alive on 5-30-, 1956, and that death occurred at 7:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul V. Starr, M.D. — ADDRESS (Street, city or town, state): Takoma Park, Md. — DATE SIGNED: 5-31-56

PHYSICIAN'S NAME (Type): PAUL V. STARR — 7400 Carroll Ave.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JUNE 2, 1956
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEO CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Miller Sons Inc — ADDRESS: Takoma Park D.C. 254 Carroll St. N.W.

24a. RECD BY REGISTRAR DATE: 6/1/56

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05320

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 60yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Viers Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: Viers Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLINTON — Middle T. — Last NICHOLS
4. DATE OF DEATH: Month May — Day 6 — Year 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-5-1890
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months 7, Days 1 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: State Road
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Walter Nichols (son) Route 2 Ellicott City — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
782.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined couse ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-6-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-9-56
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak
22d. LOCATION (City, town, or county) (State): Gaithersburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 5/14/56
24b. REGISTRAR'S SIGNATURE: Lauriel H. Fraley

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute [illegible] writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5330 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05321

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8708 Colesville Road — Apt. 102

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8708 Colesville Road - Apt.102
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle THOMAS Last OGDEN

4. DATE OF DEATH: Month May Day 16 Year 19 56

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 20, 1878
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant (retired)
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Government
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joseph Edward Ogden
14. MOTHER'S MAIDEN NAME: Ann Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ---
17. INFORMANT Address: Mrs. Maurice N. Thompson, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-16-56

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/19/56
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 5/21/56
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DE[illegible] MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible]s necessary, please exe[illegible]cute [illegible]note, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer[illegible]. Page 4 should be forwarded [illegible]e Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5331

05322 214
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1564 East-West Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 1564 East-West Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle ALOYSIUS — Last O'NEILL

4. DATE OF DEATH: Month MAY — Day 5 — Year 19 56

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 24, 1900
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Co-ordinator of Service--Shoreham Hotel
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Brooklyn, New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas A. O'Neill
14. MOTHER'S MAIDEN NAME: Anna McGrath

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes ✓ (If yes, give war or dates of service): WW #2
16. SOCIAL SECURITY NO.: 577-05-4414
17. INFORMANT — Address: Edward S. O'Neill, 1564 East-West Hgwy., SS., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Peptic ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour ___ a. m. p. m. — Month, Day, Year 19 ___
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-5-56

EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 8, 1956
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington County, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner C. Pumphrey
ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: 5/8/56
24b. REGISTRAR'S SIGNATURE: Frances Porter

TO DE[illegible] MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] necessary, please see [illegible] Page 4 should be cute [illegible] date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer[illegible] forwarded [illegible] the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as o burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5332

CERTIFICATE OF DEATH

Reg. Dist. No. 215 05323

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 914 2nd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Janet — Middle: Marie — Last: PALMER

4. DATE OF DEATH: Month: May — Day: 11 — Year: 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 22 July 1931
9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Commercial
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Frank Gordon LAMBDIN
14. MOTHER'S MAIDEN NAME: Mary E. DOTY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: James Albert PALMER (Husband) — Address: (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Pulmonary Edema	10 min.
DUE TO	(b) Bronchopneumonia	72 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO	(c) Chronic Glomerulonephritis	9 years

592x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 April 1956, to 11 May 1956, that I last saw the deceased alive on 11 May 1956, and that death occurred at 12:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P Arentzen M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 5-12-56

PHYSICIAN'S NAME (Type): Willard P. ARENTZEN, CDR, MC, USN. U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-14-56
22c. NAME OF CEMETERY OR CREMATORY: Southern Methodist Cemetery
22d. LOCATION (City, town, or county) (State): Alexandria, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Alex. Va.
CUNNINGHAM Funeral Home, Cameron & Alfred Sts.

24a. REC'D BY REGISTRAR DATE: 5-11-56
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5333

CERTIFICATE OF DEATH

05324 Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 mo. 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6413 Winnipeg Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucille — Middle: Ann — Last: Pankau

4. DATE OF DEATH: Month: May — Day: 19 — Year: 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-23-1918

9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months: 9 — Days: 26
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Merrill, Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin Sebert

14. MOTHER'S MAIDEN NAME: Randina Thronsen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: yes

17. INFORMANT: Sister — Address: Mrs. Edward Cain, 5012 N. 64th St. Milwaukee, Wis.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of liver. — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
153X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Adeno carcinoma of Colon. — 6 Mo.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 29, 1955, to date, 19____, that I lost saw the deceased alive on May 19, 1956, and that death occurred at 7:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John G. Ball M.D. — ADDRESS (Street, city or town, state): Bethesda, Maryland — DATE SIGNED:

PHYSICIAN'S NAME (Type): John G. Ball

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
22b. DATE THEREOF: 5-21-56
22c. NAME OF CEMETERY OR CREMATORY: Wisconsin Memorial Pk.
22d. LOCATION (City, town, or county) (State): Milwaukee, Wisconsin

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 5-22-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5334

CERTIFICATE OF DEATH

05325

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 18 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, NNMC, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Dist. of Columbia — b. COUNTY: Mont. P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5749 Southern St., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hugh — Middle: Germany — Last: PEARSON

4. DATE OF DEATH: Month: May — Day: 11 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 13 Feb. 1898

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Hugh PEARSON

14. MOTHER'S MAIDEN NAME: Mary DOUGLAS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - -

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: (Wife) Mrs. Verna C. PEARSON (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hepatic coma — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b): Cirhosis of the liver — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

581.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Essential Varices. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 April, 1956, to 11 May, 1956, that I last saw the deceased alive on 11 May, 1956, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William I. Freud M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, NNMC, Bethesda, Md. — DATE SIGNED: 5/12/56

PHYSICIAN'S NAME (Type): William I. Freud, LT, MC, USN — U.S. Naval Hospital, NNMC, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 5-15-56

22c. NAME OF CEMETERY OR CREMATORY: P.Wm Lee Crematory

22d. LOCATION (City, town, or county) (State): 4th & Mass. Ave., N.W. Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: LEE Funeral Home, 4th & Mass Ave., N.W. Wash, D.C.

24a. REC'D BY REGISTRAR DATE: 5-11-56

24b. REGISTRAR'S SIGNATURE: Mary E. Connelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05326

5335

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Dist. of Col. b. COUNTY: 47x-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5034 41st Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie Middle: Margaret Last: Perry

4. DATE OF DEATH: Month: May Day: 15 Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: June 26 1896

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Dist. of Columbia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George M. Stadtler

14. MOTHER'S MAIDEN NAME: Margaret Kirby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Sister-Marie Pyles, Address: 5000 Saratoga Ave. Bethesda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Encephalomalacia, left cerebrum — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b): Thrombosis left internal carotid — 5 days

DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 3, 1956, to May 15, 1956, that I last saw the deceased alive on May 14, 1956, and that death occurred at 8:25 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

ACTUAL SIGNATURE: Sidney C. Cousins M.D. 3921 Langdrum Ln. Chevy Chase 5/15/56 — DATE SIGNED

PHYSICIAN'S NAME (Type): SIDNEY C. COUSINS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-18-56

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: 5-16-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5336

Reg. Dist. No. 05327 217

1. PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck Rural
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Thelomean's Rockville

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Va — b. COUNTY Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3
d. STREET ADDRESS 2007-S. Joyce St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Sophie Middle E. Last PRICE
4. DATE OF DEATH Month May Day 23 Year 1956
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov 2 1894
9. AGE (In years last birthday) 61 Yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles A. Norton
14. MOTHER'S MAIDEN NAME Amelia Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Albert E. Price Address 2007-Joyce St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH 2 days
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — Years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes Mellitus, Fracture right femur (ununited) old injury
260
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 14, 1956, to May 23, 1956, that I last saw the deceased alive on May 20, 1956, and that death occurred at 10:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Harry J. Kircherer M.D. ADDRESS (Street, city or town, state) 2516-Pa. Ave. N.E. DATE SIGNED
PHYSICIAN'S NAME (Type) HARRY J. KICHERER

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May 26, 1956
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill
22d. LOCATION (City, town, or county) (State) Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE J. H. Lee Sons Co. ADDRESS 300-4½ St. N.E.
24a. REC'D BY REGISTRAR DATE 5-26-56
24b. REGISTRAR'S SIGNATURE Gertrude B. Fowler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5337

05328

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10543 St Paul st

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE md b. COUNTY Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington
d. STREET ADDRESS 10543 St. Paul st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Dorothy Middle C Last Probey

4. DATE OF DEATH Month May Day 23 Year 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1-10-1911
9. AGE (In years last birthday) 45 Yrs.
IF UNDER 1 YEAR Months 4 Days 13
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse
10b. KIND OF BUSINESS OR INDUSTRY P. H. Service
11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ? Mygrant
14. MOTHER'S MAIDEN NAME Chloe ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korean
16. SOCIAL SECURITY NO. No
17. INFORMANT Address J. F. Probey (Husband) Same as Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH sudden

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Frank J Bischoff M.D.
EXAMINER'S NAME (Type) FRANK J. BISCHOFF
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5-23-56

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 5-26-56
22c. NAME OF CEMETERY OR CREMATORY Parklawn
22d. LOCATION (City, town, or county) (State) Montgomery Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey
ADDRESS Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 5-25-56
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO DO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute ... Page 4 should be ... certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your file. ... forwarded to the Chief Medical Examiner's Office along with form PM3.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film Gl88 6 15 56 et

CERTIFICATE OF DEATH

05329

Reg. Dist. No. 216

5338

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4515 Avondale St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLINTON — Middle M. — Last QUIGLEY

4. DATE OF DEATH: Month May — Day 30, — Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 14, 1901
9. AGE (In years last birthday): 44 51 yrs.
IF UNDER 1 YEAR: Months 7 Days 18 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman
10b. KIND OF BUSINESS OR INDUSTRY: Fighting Fires
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James C. Quigley
14. MOTHER'S MAIDEN NAME: Mabel Hoffmaster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Wife-Doris C. Quigley — Address: Bethesda, Md. 4515 Avondale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
153X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of sigmoid flexure of colon — 17 mos.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/2 19 54 to 5/30 19 56 that I last saw the deceased alive on 5/28 19 56, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: O. L. Marks M.D. — ADDRESS (Street, city or town, state): 6306 Wisconsin Ave. — DATE SIGNED:

PHYSICIAN'S NAME (Type): I. L. MARKS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-2-1956
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak
22d. LOCATION (City, town, or county) (State): Gaithersburg Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 6-4-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05330

5339

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 14 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.F.D. # 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: R.F.D. # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willie — Middle: Ridgley — Last:
4. DATE OF DEATH: Month: May — Day: 22 — Year: 1956

5. SEX: male
6. COLOR OR RACE: col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-[illegible]-1895
9. AGE (In years last birthday): 61 Yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Ridgley
14. MOTHER'S MAIDEN NAME: Fannie Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Christine Ridgely (wife) Same as Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D. — CHIEF MEDICAL EXAMINER ☐ — DATE SIGNED
EXAMINER'S NAME (Type): Frank J. Broschart — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — 5-22-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/26/56
22c. NAME OF CEMETERY OR CREMATORY: Pleasant View
22d. LOCATION (City, town, or county) (State): Quince Orchard, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L Snowden — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE: JUN 7 1956
24b. REGISTRAR'S SIGNATURE: Alverda Cook

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05331

5340

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 7001 Hillcrest Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ALBERT — Middle C. — Last ROOT

4. DATE OF DEATH: Month May — Day 8, — Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/19/65
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Mail Service
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank A. Root
14. MOTHER'S MAIDEN NAME: Emma Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Irving C. Root-Item # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Block, complete, acute — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO
(b): Arteriosclerotic Heart Disease — 10 yrs +
DUE TO
(c): Generalised Arteriosclerosis

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic prostatism with obstruction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1955, to May 8, 1956, that I last saw the deceased alive on May 8, 1956, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stewart Clapp, M.D. — ADDRESS (Street, city or town, state): 3921 Ingoman St Wash DC — DATE SIGNED: 5-8-56

PHYSICIAN'S NAME (Type): Stewart Clapp

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 5-9-56
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 5-10-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5341

CERTIFICATE OF DEATH

05332

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
c. LENGTH OF STAY IN 1b: 139 das.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 50 The Clinical Center, NIH

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY: 47x-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 6022 Utah Avenue, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel; Middle: Felden; Last: Roth

4. DATE OF DEATH: Month: May; Day: 1; Year: 1956

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1 May 1901

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Theatre Manager

10b. KIND OF BUSINESS OR INDUSTRY: Motion Picture

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Morris Roth

14. MOTHER'S MAIDEN NAME: Pauline Felden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Not Avail.

17. INFORMANT — Address: The Medical Record, Clinical Center, NIH

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive nasopharyngeal hemorrhage
DUE TO: Pulmonary edema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Moderate aspiration of blood + blood clot
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fatty metamorphosis liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 14, 1955, to May 1, 1956, that I last saw the deceased alive on May 1, 1956, and that death occurred at 10 50 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William M Kramer M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 5/2/56

PHYSICIAN'S NAME (Type): William M. Kramer, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/4/56

22c. NAME OF CEMETERY OR CREMATORY: Wash. Hebrew

22d. LOCATION (City, town, or county) (State): Congress Heights, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: B. Danzansky & Son N.W., Wash., D. C.

ADDRESS: 3501 14th St.

24a. REC'D BY REGISTRAR DATE: 5-9-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05333

5342

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4607 Maple Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4607 Maple Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: A. — Last: ROYAL

4. DATE OF DEATH: Month: May — Day: 21 — Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 18, 1885

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: 19 Days: 3
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Johnson Co. N. Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Royal

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 577-05-7656

17. INFORMANT — Address: Mrs. Viola Royal-Same Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank J. Broschart, M. D.
DATE SIGNED: May 21, 1956

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-23-56
22c. NAME OF CEMETERY OR CREMATORY: Parklawn
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.

24a. REC'D BY REGISTRAR — DATE: 5-24-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... necessary, please exe... cute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fune... forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your fi... Page 4 should be ... r.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5343 **CERTIFICATE OF DEATH**

05334
Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 33 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 922 Rockville Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Glenn — Middle Christian — Last Sager

4. DATE OF DEATH: Month May — Day 16 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 21, 1916

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Government

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Paul Christian Sager

14. MOTHER'S MAIDEN NAME: Lydia Marie McFall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes - Active Serviceman

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pulmonary congestion and hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): acute leukemia
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): liver abcess; gastrointestinal hemorrhage

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 13, 1956, to May 16, 1956, that I last saw the deceased alive on May 16, 1956, and that death occurred at 10:23 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Mehran Goulian M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 5/17/56
PHYSICIAN'S NAME (Type): Mehran Goulian, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-17-56
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State): WAGNER S.D. DAKOTA

23. FUNERAL DIRECTOR'S SIGNATURE: Michael J. Rinaldi
ADDRESS: 816 "H" St. NE
24a. REC'D BY REGISTRAR DATE: 5-17-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

MAY 21 1956

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05335

5246

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park Md
c. LENGTH OF STAY IN 1b: 8 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5101 New Hampshire Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Anna Middle — Last Schantz

4. DATE OF DEATH: Month 5 Day 13 Year 1956

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-17-89
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?: Russia

13. FATHER'S NAME: Samuel Shapiro
14. MOTHER'S MAIDEN NAME: Hattie (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr Charles Schantz Spouse - Husband
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO
(b): Coronary atherosclerosis — unknown
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1 420x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes well it us
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-15, 1955, to 5-13, 1956, that I last saw the deceased alive on 5-13, 1956, and that death occurred at 5:10 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jason Berger M.D. — ADDRESS (Street, city or town, state): 931 Kenyon Drive — DATE SIGNED:
PHYSICIAN'S NAME (Type): Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/15/56
22c. NAME OF CEMETERY OR CREMATORY: MONTEFIORE CEM
22d. LOCATION (City, town, or county) (State): QUEENS, N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home
ADDRESS: 4217-9th NW Wash DC
24a. REC'D BY REGISTRAR DATE: 5/16/56
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1c, &2, Film G199 June 21 [illegible]

CERTIFICATE OF DEATH

05336 2/4

5344

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural KENSINGTON
c. LENGTH OF STAY IN 1b: 2 1/2 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY: 47x-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1618 Hobart St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EMMA — Middle A. — Last SCHNEIDER

4. DATE OF DEATH: Month May — Day 31 — Year 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 1, 1861

9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwin F. Brooks

14. MOTHER'S MAIDEN NAME: Emma Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Louis B.Snhneider, Silver Spring, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
331x
DUE TO: Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/1/56, 19__ to 5/30/56, 19__, that I last saw the deceased alive on 5/30/56, 19__, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: James A. O'Keeffe M.D.

PHYSICIAN'S NAME (Type): James A. O'Keeffe M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/2/56
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington D C

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph Sanders Sons 1756 Penna Ave N W Washington

24a. REC'D BY REGISTRAR DATE: 6/2/56

24b. REGISTRAR'S SIGNATURE: Frances Porter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5247 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05337 7/3
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.C.A.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: —
b. COUNTY: — 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia
d. STREET ADDRESS: 249 Hawaii Ave. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

3. NAME OF DECEASED (Type or print): First Peter Middle Walter Last Scileppy

4. DATE OF DEATH: Month 5 Day 12 Year 1956

5. SEX: Male
6. COLOR OR RACE: Wh.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-29-30
9. AGE (In years last birthday): 25 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Johnstown Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Scileppy
14. MOTHER'S MAIDEN NAME: Mary Gluchman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes, give war or dates of service) 2nd W.W. Army
16. SOCIAL SECURITY NO.
17. INFORMANT: Address: Mrs. Margaret Scileppy - Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

DUE TO (b): Acute respiratory effort (Trumpet Player) — 30 minutes

DUE TO (c): Myocardial Ischaemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Status thymicolymphaticus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Brosnhart M.D.
EXAMINER'S NAME (Type): Frank J. Brosnhart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-13-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Shipment
22b. DATE THEREOF: May 14, 1956
22c. NAME OF CEMETERY OR CREMATORY: St. John's Church Cemetery, Johnstown, Penna.
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey
ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: 5/14/56
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodds

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please exe... cate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fune... r. Page 4 should be forwarded ... he Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your fil...
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

Item 20 Film G197 5-14-56 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05338

5345

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: California
b. COUNTY: 43 X - 3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Long Beach
d. STREET ADDRESS: 835 Freeman Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lois; Middle: Ann; Last: SCRANTON

4. DATE OF DEATH: Month: May; Day: 8; Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 30 January 1956

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: 3; Days: 8; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Buel SCRANTON

14. MOTHER'S MAIDEN NAME: Isabelle Chaput

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: (Father) Buel SCRANTON (Same as #2)
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
DUE TO
(b): 3° burns 40% body, Rt. leg amputation — 18 days
DUE TO
(c): due to Gangrene; thrombophlebitis, legs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
The infant was placed by the mother, on a pillow, on or near a stove. The burner was accidentally turned on by another child of the household.

20c. TIME OF INJURY: Hour: 1640 o. n. p. m. Month, Day, Year: Apr. 20 1956

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Qtrs. Fort Campbell, Kentucky

21. I certify that I attended the deceased from 2 May, 1956, to 8 May, 1956, that I last saw the deceased alive on 8 May, 1956, and that death occurred at 7:06P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Burt C. Johnson M.D.
ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md.
DATE SIGNED: 9 May 1956

PHYSICIAN'S NAME (Type): Burt C. Johnson, LCDR, MC, USN
U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-9-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Pumphrey
ADDRESS: Bethesda, Md.
R.A. Pumphrey Funeral Home 7557 Wisc.Ave.,

24a. REC'D BY REGISTRAR DATE: 5-8-56
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, FilmG196 5-10-56 et

5346

CERTIFICATE OF DEATH

05339

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 hr.15 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, NNMC, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1117 Michigan Ave., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47x-3

3. NAME OF DECEASED (Type or print): First: John; Middle: Anthony; Last: SEITZ

4. DATE OF DEATH: Month: May; Day: 6; Year: 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 21, 1886
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-1
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Mrs. Alida M. SEITZ, Wife, Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Pulmonary Edema	2 hrs
DUE TO	420.1	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Myocardial failure due to Myocardial Infarct.	1 hr
DUE TO (c)	Coronary thrombosis, st Coronary artery	6 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 May, 1956, to 6 May, 1956, that I last saw the deceased alive on 6 May, 1956, and that death occurred at 12:45A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P Arentzen M.D.
ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md.
DATE SIGNED: 7 May 1956

PHYSICIAN'S NAME (Type): Willard P. Arentzen, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-9-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Nalley's Funeral Home
ADDRESS: Washington, D.C. 3200 R.I. Ave, Mt.Ranier
24a. REC'D BY REGISTRAR DATE: 5-7-56
24b. REGISTRAR'S SIGNATURE: Mary E. Connelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5347

CERTIFICATE OF DEATH

05340

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY: 47A.3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1023 Girard St., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Milton — Last: SELLMAN

4. DATE OF DEATH: Month: May — Day: 5 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 20 May 1897

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Frank SELLMAN (Deceased)

14. MOTHER'S MAIDEN NAME: Lizzie WINSTON (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-1

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: (Sister) Helen T. FORD (Sameas #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
340.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Pneumococcal pneumonia — 3 days.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Urethral stricture

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 May, 1956, to 5 May, 1956, that I last saw the deceased alive on 5 May, 1956, and that death occurred at 11:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold I. Passes, M.D. — M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 5-5-56

PHYSICIAN'S NAME (Type): Harold I. PASSES, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-8-56

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Morrow & Woodford Funeral Home — ADDRESS: Washington, D.C. — 24a. REC'D BY REGISTRAR DATE: 5-5-56 — 24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5348

05341

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia b. COUNTY:
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda Rural — c. LENGTH OF STAY IN 1b: 19 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83X-2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital	d. STREET ADDRESS: 1004 10th Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Ralph	Maurice	SHEAF	May	27	19 56

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		9-21-07	48 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mariner	Mariner Retired	New York	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William SHEAF	Louise TURNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	WW II	Unknown	Wife Mrs. Hazel G. SHEAF	Same as Item #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma, esophagus — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that I attended the deceased from 8 May, 1956, to 27 May, 1956, that I last saw the deceased alive on 27 May, 1956, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M. L. Gerber M.D. — ADDRESS (Street, city or town, state): USNH, NNMC, Bethesda, Maryland — DATE SIGNED: 5-28-56

PHYSICIAN'S NAME (Type): M.L. GERBER, CAPT, MC, USN — USNH, NNMC, Bethesda, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5-31-56	Arlington Nat'l Cemetery	Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Demaine Funeral Home, 520 Mt. Vernon Blvd.	Alexandria, Va.	5-28-56	Mary E. Donnelly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5349

CERTIFICATE OF DEATH

05342 216
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — COUNTY: 47 X-3

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda

c. LENGTH OF STAY IN 1b: 148 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda, Md.

d. STREET ADDRESS: 1835 Newton Street, N. W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: Victoria — Last: Snowden

4. DATE OF DEATH: Month: May — Day: 10, — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 21, 1866

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Teaching school

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Snowden

14. MOTHER'S MAIDEN NAME: Catherine Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation (bronchial obstruction) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
190X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Malignant Melanoma
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 14 1955, to May 10, 1956, that I last saw the deceased alive on May 10, 1956, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Claude E. Forkner, Jr. M.D.
ADDRESS (Street, city or town, state): The Clinical Center, The National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: May 10, 1956

PHYSICIAN'S NAME (Type): Claude E. Forkner, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/12/56

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR DATE: 5-12-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05343

5350 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: Mont. COUNTY 14 5-11 Colesville Rd. Md. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs Md. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marillea Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs Md.
STREET ADDRESS (If rural, give location) 14 5-11 Colesville Rd.

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) A (Last) Stein

4. DATE OF DEATH: (Month) May (Day) 28 (Year) 19 56

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH: 3/9/1862 | 9. AGE last birthday 94 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10B. KIND OF BUSINESS OR INDUSTRY: Housewife | 11. BIRTHPLACE (State or foreign country): Wash. D.C. | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Christian Widmayer
14. MOTHER'S MAIDEN NAME: Katherine Betz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Gertrude Wannan

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 IMMEDIATE CAUSE (A) Congestive heart failure — 2 d

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Arteriosclerotic vasc. disease

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc. | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1956 to May 28, 1956, that I last saw the deceased alive on May 28, 1956, and that death occurred at 7.45 p. M, from the causes and on the date stated above.

SIGNATURE M. D. — ADDRESS — DATE SIGNED

J. F. Ottevaere M.D. 401 Kennedy St. N.W. Washington D.C. May 28 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

5/31/56 | Prospect Hill | Washington DC

DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR — ADDRESS

5/29/56 | Frances Potter | S. H. Hines Co. | 2901-14th St. N.W.

VS. A15 — 10-55

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5351 **CERTIFICATE OF DEATH** Reg. Dist. No. 05344 2 6

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 3121 "P" Street, N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Susan — Middle Margretta — Last Stroup
4. DATE OF DEATH: Month May — Day 14, — Year 19 56
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 2, 1948
9. AGE (In years last birthday): 7 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Russell C. Stroup
14. MOTHER'S MAIDEN NAME: Louise W. Wells
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastro - Intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Acute lymphocytic leukemia
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2040
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 27, 1956 to May 14, 1956 that I last saw the deceased alive on May 14, 1956, and that death occurred at 12:25P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Schick M.D.
ADDRESS (Street, city or town, state): The Clinical Center
DATE SIGNED: May 14, 1956
PHYSICIAN'S NAME (Type): Martin Schick, M.D.
National Institutes of Health
Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 5/16/56
22c. NAME OF CEMETERY OR CREMATORY: Spring Hill
22d. LOCATION (City, town, or county) (State): Lynchburg, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. ADDRESS: 2901 14th St, N.W. Washington, D. C.
24a. REC'D BY REGISTRAR DATE: 5-16-56
24b. REGISTRAR'S SIGNATURE: Beatrice M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5352

CERTIFICATE OF DEATH

05345
Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9200 Burley Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 9200 Burley Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MAUD — Middle M. — Last SUTHERIN

4. DATE OF DEATH: Month May — Day 24 — Year 19 56

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-20-1874
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months 0 — Days 4
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Morris
14. MOTHER'S MAIDEN NAME: Susan Quinn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John W. Sutherin-Husband — Address: Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 5 m
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Endocardial fibrosis
DUE TO
(c): Arteriosclerotic heart disease — 15 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 16, 19 56, to May 24, 19 56, that I last saw the deceased alive on May 24, 19 56, and that death occurred at 8 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas L. Hartman M.D. — ADDRESS (Street, city or town, state): 1834 Eye St. N.W., Wash. D.C. — DATE SIGNED: 5/24/56

PHYSICIAN'S NAME (Type): THOMAS L. HARTMAN M.D. 1834 EYE ST. N.W. WASH. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-26-56
22c. NAME OF CEMETERY OR CREMATORY: Parklawn
22d. LOCATION (City, town, or county) (State): Rockville, Montg. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda Md
24a. REC'D BY REGISTRAR DATE: 5-28-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, FilmG197 5-22-56 et
Items 8,9 FilmG198 5-22-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 5248 — 015346223

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 41 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. San + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY: 47x-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1803 Biltmore St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Emily — Last: Swift

4. DATE OF DEATH: Month: May — Day: 15 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 18. 1878

9. AGE (In years last birthday): 77 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Fox

14. MOTHER'S MAIDEN NAME: Henrietta Sampson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO
(b): Arteriosclerotic heart disease
DUE TO
(c): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Inanition secondary to Esophageal Hiatal Hernia with Obstruction

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 15, 1956, to May 15, 1956, that I last saw the deceased alive on May 15, 1956, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Marvin L. Kolkin M.D. — ADDRESS (Street, city or town, state): 2025 Eye Street, N.W., Wash 6, D.C. — DATE SIGNED

PHYSICIAN'S NAME (Type): Marvin L.Kolkin — 2025- Eye Street N.W., Washington, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MAY 17,1956

22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cem

22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: WASH. D.C. — Martin W. Hyson & Co 1300 N. Capitol

24a. REC'D BY REGISTRAR — DATE: MAY 17 1956

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5249

CERTIFICATE OF DEATH

05347

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Pk Md
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring maryland
d. STREET ADDRESS: 109 whittier Ter.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): (Taylor) First: James Middle: Edgar Last: taylor
4. DATE OF DEATH: Month: May Day: 10 Year: 1956
5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-2-13
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman.
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Same as Edgar L. Taylor
14. MOTHER'S MAIDEN NAME: same as above Minerva Heil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Patient — Same as listed
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Bleeding duodenal ulcer — 4 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerosis
541.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan ____, 1956, to May 10, 1956, that I last saw the deceased alive on May 10, 1956, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Raymond A West M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 14 1956
22c. NAME OF CEMETERY OR CREMATORY: Rumsey Cem.
22d. LOCATION (City, town, or county) (State): Jacobsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. A. Ringsburg
ADDRESS: 7557 Wis Ave
24a. REC'D BY REGISTRAR DATE: 5/11/56
24b. REGISTRAR'S SIGNATURE: J. Nelson Rodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5353

CERTIFICATE OF DEATH

Reg. Dist. No. 053484

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda, Maryland
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kansas — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Independence
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Myrtle — Middle: Ethel — Last: Taylor

4. DATE OF DEATH: Month: May — Day: 31, — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 14, 1887

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John A. Pierson

14. MOTHER'S MAIDEN NAME: Frances Simmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: none

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema — Interval between onset and death: Hours

DUE TO (b): Bleeding esophageal varices — Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Cirrhosis — Diabetes mellitus — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myocardial infarction — Coronary heart disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 25, 1956 to May 31, 1956, that I last saw the deceased alive on May 31, 1956, and that death occurred at 8:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel D. Federman M.D.
ADDRESS (Street, city or town, state): The Clinical Center, The National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 6/1/56

PHYSICIAN'S NAME (Type): Daniel D. Federman, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/1/56
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Dudley Cemetery Kansas

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co
ADDRESS: 1400 Chapin St NW

24a. REC'D BY REGISTRAR DATE: 6/5/56
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5253

CERTIFICATE OF DEATH

05349

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville

c. LENGTH OF STAY IN 1b: One year

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 13019 Evanston St.

d. STREET ADDRESS: 13019 Evanston St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORA Middle R Last TETLOW

4. DATE OF DEATH: Month May Day 8 Year 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan 10-1882

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months 3 Days 28

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: C.O.McIntosh

14. MOTHER'S MAIDEN NAME: Maria Moulden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: M. Hough Daughter Address: Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

420.1

DUE TO (b): Arteriosclerosis — 20 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. cl. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 19--, to May, 1956, that I last saw the deceased alive on May, 19 56, and that death occurred at 9:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W.S. Murphy M.D. ADDRESS (Street, city or town, state): 6151 Wisconsin Ave Chevy Chase Md DATE SIGNED: May 9 56

PHYSICIAN'S NAME (Type): W.S. Murphy

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-10-56

22c. NAME OF CEMETERY OR CREMATORY: Monocacy

22d. LOCATION (City, town, or county) (State): Beallsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda Md

24a. REC'D BY REGISTRAR DATE: 5-11-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5354

CERTIFICATE OF DEATH

05350

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 39 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ROSMOR, 5721 GROSVENOR LANE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SPRINGFIELD — BETHESDA
d. STREET ADDRESS: 5407 - CHRISTY DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Josephine — Middle: Teresa — Last: Wall

4. DATE OF DEATH: Month: MAY — Day: 4 — Year: 1956

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 19, 1882

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): CANADA — NIAGRA FALLS, ONTARIO

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: PETER FOSTER

14. MOTHER'S MAIDEN NAME: BRIDGET SHREENAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: THOMAS H. WALL, JR. 5407 CHRISTY DRIVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respitory Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
163X
DUE TO
(b): CARCINOMA of lung — 1 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Generalized arteriosclerosis + myocardial degeneration — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/7, 1956, to 5/4, 1956, that I last saw the deceased alive on 5/3, 1956, and that death occurred at 3:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. A. Thomas M.D. — ADDRESS (Street, city or town, state): 4301 48TH ST. NW., WASH. D.C. — DATE SIGNED

PHYSICIAN'S NAME (Type): S. A. Thomas — 4301 48TH ST. NW. WASH, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MAY 7, 1956

22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY

22d. LOCATION (City, town, or county) (State): BUFFALO, NEW YORK

23. FUNERAL DIRECTOR'S SIGNATURE: H. WON. WEVOL — ADDRESS: 2224 WIS. AVE. D.C.

24a. REC'D BY REGISTRAR DATE: 5-7-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5355

CERTIFICATE OF DEATH

Reg. Dist. No. 05351 17

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Olney~~ 330 E. Diamond Ave.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ~~Gaithersburg~~ Montg. Co. Gen.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Olney~~ Gaithersburg
d. STREET ADDRESS: 330 E. Diamond Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary — Middle E. — Last Walton
4. DATE OF DEATH: Month May — Day 31 — Year 1956
5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 12, 1876
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. Walton
14. MOTHER'S MAIDEN NAME: Jane Erwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Joseph Walton - Item #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Heart Failure.	
260X		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Diabetic Coma	
DUE TO (c)	Diabetic Mellitus	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 31, 1956, to May 31, 1956 that I last saw the deceased alive on May 31, 1956, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lucino L. Ledl, M.D. — ADDRESS (Street, city or town, state): 108 N. Frederick Ave. Gaithersburg Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Lucino L. Ledl

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 6-4-56
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md
24a. REC'D BY REGISTRAR DATE: 5-31-56
24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, FilmG197 5-14-56 et

5356

CERTIFICATE OF DEATH

Reg. Dist. No. 05352 211

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Woodfield
c. LENGTH OF STAY IN 1b: I5 Years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Woodfield

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D. I Gaithersburg Md.
d. STREET ADDRESS: R.F. D. Gaithersburg Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle GRIFFITH Last WARFIELD

4. DATE OF DEATH: Month May Day I Year 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July,2 1871 1872
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles H. Griffith
14. MOTHER'S MAIDEN NAME: Hester Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Miss. Mary C, Warfield , Gaithersburg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chronic spastic colitis — 5 months.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 3, 1956, to May 1, 1956, that I last saw the deceased alive on April 30, 1956, and that death occurred at 10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Kerr M.D. ADDRESS (Street, city or town, state): Damascus, Md. DATE SIGNED: 5/3/56

PHYSICIAN'S NAME (Type): JAMES P. KERR M.D. Damascus, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 4 1956
22c. NAME OF CEMETERY OR CREMATORY: Goshen Cemt.
22d. LOCATION (City, town, or county) (State): Laytonsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber ADDRESS: Laytonsville
24a. REC'D BY REGISTRAR DATE: May 5 56
24b. REGISTRAR'S SIGNATURE: Della N. Burdette

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G198 6-8-56 et

5357

CERTIFICATE OF DEATH

05353

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac-Rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD#2 Rockville,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac-Rural
d. STREET ADDRESS: RFD#2 Rockville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUISE — Middle L. — Last WATKINS

4. DATE OF DEATH: Month May — Day 29, — Year 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 29, 1879

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months 3 — Days 3
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Stone

14. MOTHER'S MAIDEN NAME: Eliza Davidson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Russell C. Watkins- Item # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral emphia — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
350x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Bronchopneumonia — 3 days
DUE TO
(c): Parkinsonism & generalized arteriosclerosis — 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/1/, 1953, to 5/29/, 1956, that I last saw the deceased alive on 5/29/, 1956, and that death occurred at 12:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen L. Jones M.D. — ADDRESS (Street, city or town, state): Rockville Md — DATE SIGNED: 5/31/56

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-2-56

22c. NAME OF CEMETERY OR CREMATORY: Brookingsville Ch. Cem.

22d. LOCATION (City, town, or county) (State): Brookingsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 6/1/56

24b. REGISTRAR'S SIGNATURE: Laurell Kraytonpar E.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs after death. Page 4 may be filled in by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5358

CERTIFICATE OF DEATH

05354

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, NNMC, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1806 Wyoming Ave., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Oscar	Jabez	WEEKS	May	30	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		30 Sept. 1879	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mariner	U.S. Navy (Retired)	North Carolina	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jabez WEEKS	Sarah DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes — WW-I & II	Unknown	James E. WEEKS (Brother) Swansboro, N.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Portal Vein thrombosis	
DUE TO (b)	Carcinoma of the liver	Unknown.
DUE TO (c)		

156.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Portal Cirrhosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 18 May, 1956, to 30 May, 1956, that I last saw the deceased alive on 30 May, 1956, and that death occurred at 11:35A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William I. Freud M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 5-31-56

PHYSICIAN'S NAME (Type): William I. Freud, LT, MC, USNR — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	6-4-56	Arlington Nat'l Cemetery	Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
S.H. Hines Co. S.H. HINES Funeral Home, 2901 14th St., N.W., Washington, D.C.	5-31-56	Mary E. Crassella

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5359

CERTIFICATE OF DEATH

05355

Reg. Dist. No. 211

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Germantown Md
c. LENGTH OF STAY IN 1b: 10 Jrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cedar Grove Md
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: OVID Middle: H. Last: WELLS

4. DATE OF DEATH: Month: MAY Day: 28 Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 13 1894

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming own

11. BIRTHPLACE (State or foreign country): Sheffield Tenn

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: S. R. Wells

14. MOTHER'S MAIDEN NAME: Mary Bowman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217367271

17. INFORMANT: Address: Hattie A Wells Germantown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Chronic Arteriosclerosis — 15 years
DUE TO (c): Heart Disease.

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1956, to May 28, 1956, that I last saw the deceased alive on May 26, 1956, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack Schumacher M.D. — ADDRESS (Street, city or town, state): Gaithersburg, Md — DATE SIGNED: 5-29-56

PHYSICIAN'S NAME (Type): Jack Schumacher

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 31 1956

22c. NAME OF CEMETERY OR CREMATORY: Salem

22d. LOCATION (City, town, or county) (State): Cedar Grove Md

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Boyds Md

24a. REC'D BY REGISTRAR DATE: June 1 5-6

24b. REGISTRAR'S SIGNATURE: Della R. Burdette

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05356

5360

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY: Montgomery — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 9401 Thornhill Dr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. — COUNTY: Mont.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
STREET ADDRESS (If rural give location): 9401 Thornhill Dr.

3. NAME OF DECEASED (Type or Print): (First) HELEN (Middle) (Last) WESTCOTT

4. DATE OF DEATH: (Month) May (Day) 20 (Year) 1956

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: APRIL 14, 1874

9. AGE last birthday: 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES HASKEL MOSES

14. MOTHER'S MAIDEN NAME: ELIZABETH HITCHCOCK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: HENRY H. WESTCOTT, RANCOCAS WOODS, N.J.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

153X

IMMEDIATE CAUSE (A) Mucoid carcinoma of the colon with metastases to the liver — 1 year

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic heart disease with decompensation 1 month

19A. DATE OF OPERATION: October 15, 1955

19B. MAJOR FINDINGS OF OPERATION: Mucoid carcinoma of ascending colon

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July ..., 1955, to May 20, 1956 that I last saw the deceased alive on May 12, 1956, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

SIGNATURE: Bennet A. Porter, Jr. M.D. — ADDRESS: M.D. 9301 Colesville Rd., Silver Spring Md. — DATE SIGNED: May 20, 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 5/23/1956 — NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem. — LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REGISTRAR: 5-24-56 — REGISTRAR'S SIGNATURE: Frances Fuller

24. FUNERAL DIRECTOR — ADDRESS: Joseph Daniels Sons, 1756 Pa. Ave., N.W. Wash., D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5361

CERTIFICATE OF DEATH

Reg. Dist. No. 05357 2 16

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN 1b: 2 1/2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6816 Brookville Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
d. STREET ADDRESS: 6816 BROOKVILLE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOROTHY — Middle — Last WHITE

4. DATE OF DEATH: Month MAY — Day 5 — Year 1956

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 9, 1895

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY

10b. KIND OF BUSINESS OR INDUSTRY: GOVERNMENT

11. BIRTHPLACE (State or foreign country): ROCHESTER, PA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BERNARD WARTSKI

14. MOTHER'S MAIDEN NAME: ROSA USTANES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ###

17. INFORMANT: HARRY F. WHITE
Address: 6816 BROOKVILLE ROAD, CHEVY CHASE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of uterus with
DUE TO
(b): extension to rectum
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

174X

INTERVAL BETWEEN ONSET AND DEATH: 8 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/13, 1956, to 5/5, 1956, that I last saw the deceased alive on 5/5, 1956, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold F. McCann M.D.
ADDRESS (Street, city or town, state): 3008 - 14th St. N.W. Washington, D.C.
DATE SIGNED: 5/5/56

PHYSICIAN'S NAME (Type): HAROLD F. McCANN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 8 1956
22c. NAME OF CEMETERY OR CREMATORY: Laytonsville Cemt.
22d. LOCATION (City, town, or county) (State): Laytonsville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber
ADDRESS: Laytonsville, Md.

24a. REC'D BY REGISTRAR DATE: 5-9-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5362

CERTIFICATE OF DEATH

05358

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 9 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5901 31st Place, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Otis — Middle: (n) — Last: WILDMAN

4. DATE OF DEATH: Month: May — Day: 14 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 13, 1890

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy (Retired)

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William A. WILDMAN

14. MOTHER'S MAIDEN NAME: Kate KENDRICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW-I & II

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: (Wife) Mrs. Carrie WILDMAN (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 9 hours

420.1

DUE TO (b): Coronary arteriosclerosis — 15 years (Appx)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 May, 1956, to 14 May, 1956, that I last saw the deceased alive an 14 May, 1956, and that death occurred at 10:43 P.M., from the causes and on the date stated abave.

ACTUAL SIGNATURE M.D. — ADDRESS (Street, city or town, state): U.S.Naval Hospital, NNMC, Bethesda, Md. — DATE SIGNED: 5-15-56

PHYSICIAN'S NAME (Type): Bruce L. CANAGA, CAPT, MC, USN — U.S.Naval Hospital, NNMC, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 17 May 1956

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey Jr. — ADDRESS: Bethesda, Md. — R.A.PUMPHREY Funeral Home, 7557 Wisconsin Ave.,

24a. REC'D BY REGISTRAR DATE: 15May 1956

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5363 **CERTIFICATE OF DEATH**

Reg. Dist. No. 05359

1. PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b: 20 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1232 - Noyes Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,
d. STREET ADDRESS 1232 - Noyes Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Walter — Middle SUMNER — Last Wilson,
4. DATE OF DEATH: Month May — Day 15, — Year 1956

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 25, 1892
9. AGE (In years last birthday) 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN OF MACHINE OPERATORS
10b. KIND OF BUSINESS OR INDUSTRY: PEP CO.
11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES S. WILSON
14. MOTHER'S MAIDEN NAME: CORA ECCLESTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW#1
16. SOCIAL SECURITY NO.: 577-05-0856
17. INFORMANT — Address: MRS. GERTRUDE WILSON, 1232 NOYES DRIVE SILVER SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Myocardial Infarction,	Immediate.
DUE TO (b)	Acute Coronary Artery Thrombosis	"
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Coronary Arteriosclerosis,	10 yrs.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1948 19__, to May 15, 1956, that I last saw the deceased alive on May 14, 1956, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE James W. Long, M.D. ADDRESS (Street, city or town, state) 915 - 19th St. NW, Wash. D.C. DATE SIGNED

PHYSICIAN'S NAME (Type) JAMES W. LONG 915 19th ST., N.W., WASHINGTON, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/17/56
22c. NAME OF CEMETERY OR CREMATORY: GLENWOOD CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner C. Pumphrey ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 5-21-56
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05360

5364 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: ~~Xxxx~~ Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7127 Braeburn Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 7127 Braeburn Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEO — Middle A? — Last WOLFSOHN

4. DATE OF DEATH: Month May — Day 24, — Year 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 4, 1890

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months 4 — Days 20
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gov't. Emp.

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob M. Wolfsohn

14. MOTHER'S MAIDEN NAME: Rebecca Bornstein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Joel Wolfsohn-Item # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-25-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-27-1956
22c. NAME OF CEMETERY OR CREMATORY: National Mem. Park
22d. LOCATION (City, town, or county) (State): Falls Church Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Goldberg Funeral Home Washington, D.C.

24a. REC'D BY REGISTRAR DATE 5-26-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5365 **CERTIFICATE OF DEATH** Reg. Dist. No. 05361 2/16

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4522 Middleton Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4522 Middleton Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert Middle: Hall Last: YOUNG

4. DATE OF DEATH: Month: May Day: 13 Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 30, 1874

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months 11 Days 14 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Patent Attorney

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nicholas E. Young

14. MOTHER'S MAIDEN NAME: Mary E. Cross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): WWI (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Fanny Hempstone Young-Same Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

443X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) hypertensive heart disease — 2 years

DUE TO

(c) hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September, 1953, to 13 May, 1956, that I last saw the deceased alive on 13 May, 1956, and that death occurred at 4:55 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: John M. Wyman M.D. 7659 Geo-getown Road. 14 May 56

PHYSICIAN'S NAME (Type): John M. Wyman Bethesda 14, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/16/1956

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda

24a. REC'D BY REGISTRAR DATE 5-16-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05362

5366

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 302 das.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center National Institutes of Health, Bethesda

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Henrico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Richmond
d. STREET ADDRESS: 2000 Southcliffe Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lee — Middle: Hammer — Last: Zirkle

4. DATE OF DEATH: Month: May — Day: 2, — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 February 1910

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles A. Hammer

14. MOTHER'S MAIDEN NAME: Bertha Loewner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: The Medical Record, Clinical Center, NIH.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Perforation of ascending colon & massive G-I hemorrhage
DUE TO (b): Metastatic carcinoma of breast
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

170X

INTERVAL BETWEEN ONSET AND DEATH: 24-48 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 5, 1955, to May 2, 1956, that I last saw the deceased alive on May 2, 1956, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur G. Ship M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 5-2-56

PHYSICIAN'S NAME (Type): Arthur G. Ship, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 2. 1956

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): Richmond, Va

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Faltamell

ADDRESS: 3619-24th St NW Washington DC

24a. REC'D BY REGISTRAR DATE: 5/3/56

24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55